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The construction of professional identity in undergraduate pre-registration student nurses

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***The Construction of Professional Identity
in Undergraduate Pre-Registration
Student Nurses***

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Thesis submitted for the degree of

Doctor of Philosophy

**Florence Nightingale Faculty of Nursing,
Midwifery & Palliative Care.**

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Abstract

Background-

Recent changes to nurse education, and public scrutiny of the nursing profession, has led to an increasing interest in the preparation of student nurses for professional practice. Central to the advances in professional practice is the development of a professional identity that accurately reflects the role of the nurse and the function of the profession. Existing research into socialisation of student nurses are primarily introspective and offer insights into microsocial processes involved in nurse education. There is a paucity of research that explores the impact of macrosocial constructions of nursing that influence socialisation and establish professional identity.

Methods-

A constructivist grounded theory approach was used to explore undergraduate student nurse's perceptions of nursing's professional identity, throughout the pre-registration programme. First, second and third-year student nurses from two UK nursing faculties (n=63) took part in one of 12 focus groups. Students were subsequently invited for an individual interview in the following year of the programme (n=23). The data were coded and analysed. Subsequent analysis of the data was undertaken by the examining Macro, meso and microsocial processes that the students described.

Results-

Students revealed a dualism between the identity of professional nurses, and of the nursing profession. They had a strong commitment to the professional requirements

of commitment, caring and compassion; characteristics that represent authenticity with their self-concept. However, they described the identity of the profession as being passive, powerless and bound to its historical image. Students described the conflicting identities of “being part of a new generation” whilst simultaneously being required to align themselves to outdated stereotypes of nurses and nursing. Analysis demonstrated how macrosocial processes influenced students’ Individual Professional Identity (IPI) prior to commencing the programme. However, their ideas of nursing’s Professional Role Identity (PRI) was re-orientated over the 3 years of the programme, as they attempted to reconcile conflicting identities. These conflicts were compounded by a public discourse that constructs nursing as failing in its duty to care for patients and having lost sight of its roots as ‘the caring profession’.

Conclusions-

Students perceptions of the nursing profession are constructed from broad social influences that shape their professional identity. The ideas that construct their professional identity are developed prior to their entry to the programme and remain stable throughout the 3 years. A historical discourse of the nursing profession, that is founded upon nursing’s vocational roots and portrays nurses as passive and powerless, conflicts with a contemporary discourse that portrays nurses as highly skilled and knowledgeable professionals, that are at the forefront of healthcare provision. Social constructionism reveals a new interpretation of professional identity and the discourses that come to bear on student nurses during the pre-registration undergraduate programme.

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1 Introduction

This thesis is concerned with the development of professional identity in undergraduate pre-registration student nurses. Specifically, this work seeks to explore how professional identity in nursing is constructed through social influences that operate at various levels of social life. This chapter introduces the reader to the context of the study, the rationale for undertaking the study and the scope of the investigation. An introduction to the contemporaneous political, social and professional landscape in which the study is situated, will be presented.

Interest in the field of professional identity of nurses has a history that extends back to the early days of nursing. Whilst the term *professional identity* was not explicitly employed, an interest in who nurses are, how they should be and their function in society, can be identified in the work of nursing pioneers such as Florence Nightingale. In a letter to trainee nurses at St Thomas' Hospital in 1881, Nightingale expounded the requirement for the nurse to be "a good woman" who is in possession of "quietness, gentleness, patience, endurance and forbearance", and seeks to be "good rather than clever" (Nightingale 1881). Representations of nurses have been pervasive since that time and have assumed a broad spectrum of cultural stereotypes. Gendered imagery of nurses as handmaidens, battle-axes, sex kittens and angels have been reproduced by popular media, film and television (Jinks and Bradley 2004). Whilst these presentations of the nursing profession appear to have no foundation in the reality of contemporary practice, reference to them are sometimes still evident. The public's perception of nurses is important to the aims of the nursing profession. Gaining the trust of the patient is essential to the interpersonal relationship that

nurses form with them; a trust that is predicated on the acknowledgement of nurses being of good moral and ethical standing. Occasionally, press coverage of cases where the quality of nursing care is either absent or malicious, bring to the fore a public concern about the state of the nursing profession. When the Francis Report into the high mortality rate at the Mid Staffordshire NHS Trust was published (Francis 2013), the ensuing public outcry was weighted heavily toward concerns about the character and moral standing of, not only the nurses in that trust, but of the profession as a whole. The response from the profession appeared to support this. Peter Carter, the General Secretary of the Royal College of Nursing (RCN), suggested that nurses were ‘no longer up to the mark’ (Carter 2011). This portrayed an identity crisis whereby the espoused values of nursing seemed to be at odds with the evidence being presented. It is in this context, with concerns being raised about the type of people entering the profession, that nursing has been forced to re-evaluate its identity. This self-conscious introspection may reflect nursing’s discomfort with a professional identity that is bound to its origins as a form of gendered and class-bound domestic work (Kelly et al. 2012). The negative stereotypes, and inaccurate portrayals of nurses might potentially affect the status of the profession, impact recruitment and affect nurses’ sense of self (Darbyshire 2010). Recruitment of students onto undergraduate programmes has (at the time of writing this thesis) become an important issue to Universities. Shortfalls in applications of 23% have been reported in the first year following the discontinuation of the government bursary (Ford 2017), it has become more important than ever to identify how the nursing profession’s identity is being viewed by potential applicants. Recruitment strategies are designed to identify those applicants that possess the requisite attitudes and skills that recruiters consider to be desirable for nursing. The question of ‘who

decides' is pertinent when considering what is desirable. What is the reference against which a potential recruit is measured? The use of psychometric testing and tools such as the *Nurse Match Instrument* have gained popularity as they are considered to be effective at identifying those who exhibit appropriate values and attributes (Mazhindu et al. 2016, Cowin et al. 2013). Ways of discovering the person who might become a good nurse might only be effective if we have a definitive answer to the question of 'what is a good nurse?'. Where debates about the state of the nursing profession have arisen from public criticism, the answers to this question have not been consistent (Nelson 2006). A caring attitude is of foremost importance in some definitions, but this has been suggested to reveal ideologies and systems of power brokerage at work in shaping nursing (Fealy 2004). Furthermore, caring itself might be too vague and ambiguous a concept to describe nurses in a meaningful way (Sargent 2012, Morse 1990). However, the identity of nursing as *the caring profession* has endured, and provides fuel to criticism of undergraduate student nurses as being 'too posh to wash' or 'too clever to care' (Gallagher 2005, Gill 2004, Scott 2004). Unravelling the complexity surrounding nursing's professional identity has become imperative for the future of nurse recruitment, education and professional practice. This process of elucidation begins with an exploration of how professional identity is constructed, and how these constructions shape the emerging professional identity of student nurses. For this purpose, this study adopts a social constructionist stance. In social constructionism, social reality is viewed as the product of ideological work (Berger and Luckmann 1967). A discourse of nursing is produced by society through the use of ideas, images and metaphor (Burr 2015, Crowe and Crowe 2005). How undergraduate pre-registration student nurses construct professional identity is the primary aim of this study.

The primary motivation for undertaking this study arose from an earlier debate about the role of nurse education in preparing nurses for practice. As an educator, I became concerned about the antagonistic responses, from both public and professional commentators, to the mandated move towards an all-graduate nursing profession. The debate about the need for nurses to hold a Bachelor's degree has existed within the profession since the first nursing degrees were awarded in the 1960's (Brooks and Rafferty 2010). However, the compulsory degree-level entry onto the professional register expanded this debate out into the public sphere, with debates being held on daytime talk shows and many newspaper column inches being dedicated to the subject. Concerns about whether nurses need to be educated or whether just being caring was enough, set the tone of the debate. Often, the stereotypes of nurses as angels and doctor's assistants re-emerged to undermine the argument that modern healthcare requires a very different kind of nurse to those whom were practicing when those descriptors might have been relevant. This study was designed to explore how students, despite this ongoing debate, were impacted by these social influences. I felt that we, as educators should be cognisant of the way that students are being inducted into the profession; how they become professional nurses; and, most importantly, how their professional identity is shaped by the myriad of social influences that impact on the nursing profession.

Constructivist grounded theory was adopted as the most suitable approach for the design and analysis of this study. As a registered nurse and educator, I am enmeshed in the same professional sphere as the students who participated in the study; albeit

in different capacity. Although my own nurse education (in the late 1980's) was quite different to that of the students, my involvement in nurse education for the past 17 years has meant that my daily life is involved with the experiences of undergraduate student nurses. As such, a truly objective interpretation of the participants' narratives would be impossible. Rather than this being a limitation to the study, it allows both researcher and participant to generate richer and more meaningful interpretations of the phenomena (Charmaz 2014). Being a part of the same professional milieu as the students in the study afforded me an opportunity to immerse myself in the experiences being discussed. Reflexivity is an integral part of this thesis. At all stages of the research design, data collection, analysis and formulation of conclusions, self-reflection about my position as the researcher was considered. A statement explaining my position as a nurse and educator is presented in the methods chapter, and a reflection on the process is articulated in the discussion.

1.1 Structure of the thesis

This thesis will proceed with an introduction to the context of the study. A background of the milestones in the history of nursing will be presented to provide an insight into how the nursing profession has been developed in response to social and political events. This background will relate the history of nursing to its epistemological development; orientating the reader to the current status of undergraduate pre-registration nurse education. The background chapter will conclude with an overview of the theoretical approaches to the study of identity.

A systematic literature review on professional identity in nursing is presented in chapter 3. This review locates the current study in the existing literature and seeks to highlight the definitions, and the theoretical approaches used in recent studies of professional identity in nursing. Chapter 4 begins with a discussion of the research question, and the aims and objectives of the study. The justification for choosing constructivist grounded theory method to address the research aim is explored. This is followed by a detailed description of the data collection methods, the analytical procedures, ethical considerations, and the attention to rigor within the study's design. Chapter 5 provides an overview of the analysis, analytical considerations and introduces the organisation of the findings chapters. The findings from the analysis of the data are presented in chapters 6, 7 & 8. Each chapter employs a separate level of social analysis (Micro, Meso and Macrosocial) to structure the findings. Extracts from the transcribed data are used throughout as exemplars of the emerging concepts. Descriptions of the interrelationship between the concepts that arise from

each level of analysis are given. The processes that describe the development of professional identity are summarised at the end of chapter 8.

Chapter 9 discusses the findings of this study by locating them within the existing literature. A redefinition of professional identity is suggested. This new interpretation of professional identity is then discussed in relation to the processes involved in its development. Finally, the social construction of professional identity is explored as a product of competing discourses. Chapter 10 concludes the thesis with reflections on the contribution to knowledge, implications for practice, recommendations for future research, and considerations about the strengths and limitations of the study.

2 Background

In this chapter, the historical and theoretical context of the study will be discussed. Firstly, recent and historical changes that have taken place in the nursing profession will be explored. Particular attention will be paid to the significant milestones that have impacted upon the status of nurse education in the UK, and on the profession as a whole. Further discussion will be presented about the changes that took place during the time that the study was undertaken, as frequent references to recent events were made by the participants in this study.

An overview of the current structure of nurse education will be described so that the nurse education programme- in which the students participating in the study were undertaking- can be better understood. This will be accompanied by a discussion about significant changes that have occurred to professional practice in recent years; the evolving role of the nurse in contemporary healthcare delivery will also be explored.

Secondly, the theoretical background to professional identity will be discussed. The different philosophical perspectives on identity will be presented to provide conceptual definitions of identity and identity construction. The historical literature on professional identity including the key works that have informed the current understanding of identity in nursing will be reviewed. The literature review (Chapter 3) examines recent approaches to the study of professional identity in nursing, this chapter will provide a context in which to place that literature into the wider body of knowledge on the subject.

2.1 Milestones in the history of nursing

From the inception of the first schools of nursing through to the present day, there are certain key events that have transformed the way in which nursing roles have been changed, and the way in which nurses are prepared for professional practice. Some of these changes have occurred due to social and political events, others are representative of epistemological shifts that have come about as the profession has adapted to these events. Presented here is not an exhaustive history of nursing but a contextual overview of how these key events have cumulatively transformed the nursing profession into what it is today.

2.1.1 Professionalisation of nursing in the UK

The history of the nursing profession can be traced back to the early 20th Century. Despite the inaugural school of nursing being founded on the site of St Thomas' Hospital in London by Florence Nightingale in 1860, nursing was not granted its status as a profession by UK law until the passing of the Nurses Registration Act in 1919. Florence Nightingale's contribution to the nursing profession (despite her alleged resistance to the professionalisation of nursing) is denoted by her formation of a school of nursing to provide nurses with a structured programme of instruction. In a letter to Sir Thomas Watson in 1867, Nightingale had expressed concern that nursing had previously been "left to those who were too old, too weak, too drunken, too dirty, too stupid or too bad to do anything else" (Gaffney 1982). Her school of nursing was therefore an attempt to transform nursing through the establishment of a workforce that, by implication, were young, strong, sober, clean, intelligent and

good. These values resonate through her written work, particularly her *Notes on Nursing* (Nightingale 1898). Furthermore, these values underpin the behaviours and attributes of nurses that are frequently cited as the central tenets of nursing in the literature published since that time. Moreover, the current professional regulatory guidelines from the NMC can have their ethical and behavioural origins traced back to these original assumptions.

The Nurses Registration Act of 1919 led to the inauguration of the first regulatory body for the new profession. The General Nursing Council was formed in 1921 and oversaw the regulations for entry to the profession and maintained the first register of nurses. Initially, registration was voluntary but, by 1925, the first state examinations were held, and this became a mandatory requirement for all professionally registered nurses from that point forward. Successfully passing the state examination granted the nurse the title of State Registered Nurse (SRN). This is the first point in the history of nursing when nurses were only granted their professional status as a result of their educational attainment, and formal assessment by examination. Epistemologically, this shift is a significant juncture for nursing. Nurses were beginning to develop an identity that was based upon the acquisition of knowledge, in addition to the demonstration of the appropriate values and attitudes.

With the growth of nursing schools throughout the UK, instructional texts were published to support the training programmes. One such text “The Principles and Practice of Nursing” was first published in 1922 in the United States but also became

a core textbook for student nurses in the UK. In the 4th^t edition (published in 1926), the ‘spirit, ideals and point of view desirable’ in nurses were laid out:

“Sympathy, kindness and unselfishness are needed but also something more- something deeper and more helpful, more loving and spiritual which may support the patient with a feeling of strength, security, and comfort...It is our part not only to do the right things but to enjoy, to look and act as though we enjoyed.”

(Harmer 1926:p5)

The spiritual and vocational aspects of the nurse’s work and their description of the type of person that the nurse is expected to be, allude to the origins of nursing as provided by religious orders dating back several centuries (Capparelli 2005).

Moreover, in this book, Harmer describes nursing as *“distinctly woman’s work- the one profession in which women are admitted by all to excel men”* (p5). The image of nursing as a primarily female occupation highlights the cultural associations in western cultures of ‘middle-class femininity’ that, at the time, were associated with sensitivity, passivity and a delicate temperament (Hallam 2000).

The two World Wars of the first half in the 20th century, transformed the nation’s attitude to women in work; during the wars, women undertook many roles previously associated with a male workforce to aid the ‘war effort’. Furthermore, the need for nurses to care for the returning war-injured men and to attend to the nation’s public health crisis, arising from a worsening economic situation at home, significantly increased the demand for more nurses to be trained (Abel-Smith 1975).

During the period from the end of the Second World War through to the end of the 20th century, nursing underwent dramatic and profound transformations. Following the war, the loss of young men in the workplace, and the increasing numbers of women who had attended to the injured during the conflict, extended the role and enhanced the status of nurses (D'Antonio 2002). Prior to the Second World War, nursing was focused primarily on the maintenance of public health and the care for patients in the home. Young women were now being recruited to assist surgeons in field hospitals and to rehabilitate the war injured on their return home, nurses found themselves in an unprecedented position of female power and autonomy (Abel-Smith 1975, Fletcher 1997, D'Antonio 2002). The shortage of registered nurses that had begun in the 1930's, and had been exacerbated by war, led to the introduction of a 'second level' or 'assistant' nurse to fill staffing gaps. The State Enrolled Assistant Nurse (SEAN) was first recognised in the Nurses Act of 1943). These nurses underwent a 2-year training compared to the 3 years that State Registered Nurses (SRN) were required to complete. The SEAN programme (later shortened to SEN- State Enrolled Nurse) focused on practical skills and the ability to assist SRN's with day to day nursing tasks (Brown 1994).

The inception of the National Health Service (NHS) in 1948- and developments in medical treatments (such as the introduction of Penicillin in 1942)- transformed the philosophy of health and healthcare (O'Dowd 2008). Patients who had previously been unable to afford medical care could now request free treatment from the NHS, which subsequently revealed the true extent of unmet healthcare needs in the population (Limmins 1998). New roles for nurses in the provision of care and a requirement for nurses to be educated to meet a widening range of healthcare needs,

led to changes in nursing education and a subsequent transformation of nursing knowledge.

2.1.2 The emergence of Nursing Theory

In the first two decades following the second world war, nursing began to develop a knowledge base that was distinct from the medically orientated knowledge that had underpinned nurse education in the years beforehand. The development of nursing theory that was centred on nursing as a unique and discreet profession became evident through the work of nursing scholars such as Hildegard Peplau (1909-1999), Virginia Henderson (1897-1996), Ida Jean Orlando (1926-) and Joyce Travelbee (1926-1973). With a growing nursing workforce and the changes to the nurse's role in the healthcare team, a need to organise and articulate nursing knowledge became imperative. Degree courses in nursing were becoming available (albeit at a limited number of universities) and the emergence of nursing as a discipline- distinct from medical sciences- coincided with the publication of a plethora of nursing theories that sought to provide an empirical basis for nursing knowledge (see Table 2-1). Prior to the publication of these seminal texts, nursing knowledge existed in many forms, but each shared a common core that the new theories attempted to explain. At the time, nursing was still allied to the medical sciences, which held authority over the care of the sick; nursing theories were developed as an attempt to assert the unique value and contribution of nursing (Chinn and Kramer 1999). This unique knowledge was denoted by the focus on the patient as a person rather than as a medical condition or diagnosis. Furthermore, the interpersonal relationship that exists between nurse and patient became a central element of this emerging science of nursing.

Florence Nightingale had emphasised the importance of the nurse maintaining only the most limited of interactions with her patient and stated that “patients who are really ill, do not want to talk about themselves” (Nightingale 1898). However, the theories of nursing emerging in the 1950’s to 1990’s outline the importance of developing person-centred and individualised care that is developed out of active communication with the patient. In half a century, nursing had been transformed from a profession that was only concerned with the application of poultices, the administration of medicines, maintaining a light and sanitary environment (Nightingale, 1889), into a profession that was now also concerned with developing a deep understanding of the patient through advanced interpersonal skills and psychosocial assessment. The changes to the role of the nurse is evident through this development of nursing science and represents an epistemological shift which continued into the 21st century.

Chronology of Nursing Theories		
Date	Theorist	Theory/Publication
1859	Florence Nightingale	Notes on Nursing: What it is and what it is not
1952 1964	Hildegard Peplau	Interpersonal Relations in Nursing Basic principles of patient counselling
1955 1966	Virginia Henderson	Textbook for the Principles and Practice of Nursing The Nature of Nursing: a definition and its implications for practice, research and education
1958 1961	Ida Jean Orlando	The Nursing Process The dynamic Nurse-Patient relationship
1964	Ernestine Wiedenbach	Clinical Nursing: a helping art
1966, 1971	Joyce Travelbee	Interpersonal Aspects of Nursing
1970 1980 1989	Martha Rogers	An introduction to the theoretical basis of Nursing Nursing: A science of unitary man Nursing: A science of unitary human beings
1971	Imogene King	Toward a theory of Nursing: General Concepts of Human Behaviour
1971	Dorothea Orem	Nursing Concepts of Practice
1976	Dorothy Johnson	Behavioural Systems and Nursing
1976, 1984, 1991	Calista Roy	The Roy Adaptation Model
1976	Josephine Paterson & Loretta Zderad	Humanistic Nursing
1978 1980	Madeline Leininger	Transcultural Nursing: Concepts, Theories and Practice Caring: a Central Focus of Nursing
1978	Barbara Carper	Fundamental Patterns of Knowing in Nursing
1979 1985 1989	Jean Watson	Nursing: The Philosophy and Science of Caring Nursing: Human Science and Human Care Watson's philosophy and theory of human caring in nursing
1979 1983	Margaret Newman	Theory development in Nursing Newman's health theory
1982	Betty Neuman	The Neuman's systems model: A total person approach to patient problems
1983	Joyce Fitzpatrick	Fitzpatrick's rhythm model: analysis for Nursing Science
1984 1989	Patricia Benner	From Novice to Expert: Excellence and power in Clinical Nursing Practice Primacy of Caring

Table 2-1 Chronology of nursing theories (Adapted from Chinn and Kramer 2014)

2.1.3 The Nursing Process

The desire to develop nursing as a discipline that was distinct from- and yet still aligned to- the medical sciences brought forth a plethora of theories and scholarly texts that defined nursing practice in terms of concepts and theories. As nursing sought to gain legitimacy as a profession, there was an imperative to assert its academic credentials (McCrae 2011) and to articulate a distinct theoretical framework for practice that would prevent nursing from being exposed to external control (MacDonald 1995). Thus, nursing theories and models of care were intended to guide practice, curriculum design and research that would support the future development of professional nursing knowledge.

Originating in the US, an era of nursing scholarship that had begun in the late 1950's, gained momentum in both the US and UK during the 1960's and 70's. In an examination of the British Nursing press during this time, De La Cuesta (1998) found that there was a growing discontent and internal debate about the existing system of care delivery that was criticised as being task-orientated, non-individualistic and the cause of low levels of job satisfaction. Some of the nursing theories that emerged were adapted from those already in use within the medical profession. The most notable of these was the application of the *scientific method of nursing* that was developed by Ida Jean Orlando; later to become known as *The Nursing Process* (Orlando 1961). This process built upon the diagnostic procedures used by Doctors and described a series of steps that create a systematic plan of care for each individual patient. The care plan created would be based upon the nursing care needs of the patient rather than focusing on the diagnosis and treatment of a

medical condition. Orlando suggested that doctor's orders were "*for the patient, and not for the nurse*"; that nurses should be creating their own individualised nursing care plans which would be documented separately from the medical notes (ibid). The nursing process consisted of 4 steps: Assessment; Planning; Implementation; Evaluation and were presented as a continuous cycle (see Figure 2-1). The nursing process was embraced as an educational tool initially, but became a framework for practice by the 1970's. An explanation for this shift appears to have come about due to nurses in the US and UK being encouraged to undertake post qualification training. In these training courses, nurses were exposed to the concept of applying this new systematic Nursing Process to their own practice. Later, pre-registration nurse education adopted the nursing process as a foundation of practice learning and critical decision-making. The adoption of the nursing process resulted in a rapid mass re-socialisation of the nursing workforce towards a new approach to care (De La Cuesta 1998).

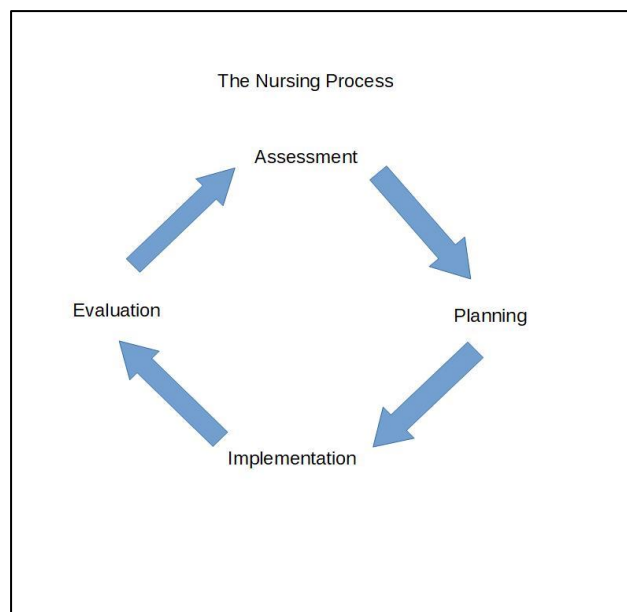


Figure 2-1 - The Nursing Process

The widespread adoption of a systematic process of assessment, planning, implementation and evaluation required nurses to possess additional skills in critical thinking and independent decision-making that had not featured in nurse education beforehand (De La Cuesta 1998). The parallel activities of implementing medical orders and developing nursing care plans created an important epistemological milestone- and point of departure- for the nursing profession (Brooks and Rafferty 2010, Brooks 2011). Nursing was establishing itself as a distinct academic discipline as a corollary of the requirement that nurses acquire additional skills and knowledge to support the assessment, planning and evaluation activities associated with the Nursing Process.

In 1977, the Nursing Process was rolled-out across the UK following the publication of the General Nursing Council for England and Wales (circular 77/19). In this circular, a new syllabus for nurse training was proposed, in which:

“The use of [the stages of the nursing process] commits all concerned in the various caring/learning situations to a shared approach and a common purpose” (GNC 1977).

The nursing process was ideological in the sense that it emerged as a body of ideas that addressed problems and trends in the profession at the time (e.g. task-orientation and inflexible approaches to care) (De La Cuesta 1998). The broader project of developing theoretical foundations for practice gave nursing grounds for legitimacy among other established healthcare disciplines (McCrae 2011, Brooks and Rafferty 2010).

2.1.4 Project 2000 and the changing status of nursing students

Up until the late 1980's, the majority of UK nurses were prepared for practice in hospital-based schools of nursing and were awarded a Certificate of Nursing and entry onto the professional register as a State Registered Nurse (SRN) on completion. Schools of nursing were an integral part of the hospital structure with students completing their education within the jurisdiction of that organisation. Nurses qualifying under this system were identified as being part of the hospital institution and took on an identity that was aligned to that hospital. Student nurses would therefore develop an institutional identity that was embodied in local rituals, routines, uniforms and badges that reinforced institutional norms and a sense of belonging (Shaw and Timmons 2010, Bradbury 1990).

Following the Conservative Government's White Paper on NHS reforms in 1989, *Working for Patients*, a new strategy for Healthcare services was implemented. The inception of the 'market economy' in healthcare, whereby the provision of services was opened up for competitive tender by District Health Authorities and hospitals, resulted in a centralisation of funding for nurse education. Three years earlier, the United Kingdom Central Council (UKCC), had conceived a new strategy (*Project 2000*). Within this strategy, it was proposed that all nurse education should be moved out of hospitals and into Higher Education Institutions. Additionally, the award for completion of the programme would be that of a Diploma in Healthcare (DipHE) that could be undertaken in one of four branches of nursing (Adult, Child, Mental Health and Learning Disabilities), with a one-year Common Foundation Programme (CFP) for students of all branches, in the first year. (UKCC 1986). The State

examination was replaced by a system of continuous theoretical and practice-based assessments. The SRN title was also changed to either Registered General Nurse (RGN), Registered Mental Health Nurse (RMN) or Registered Sick Children's Nurse (RSCN).

Despite the idea of nurse education moving from hospital to higher education institutions originally being proposed by the UKCC, the primary motivation for its implementation appears to be a result of changes to the funding arrangements in the NHS (Burke 2006a). District Health Authorities were able to divert money, that had previously been provided directly to hospitals to train nurses, to other services. The replacement of the direct funding to hospitals for nurse education, with a contractual arrangement with HEI's to do the same, was a convenient and potentially cost-effective measure, despite this never having been a part of the government's original policy (Cox 1992). Other DHA's followed this model and, by 1995, the last of the schools of nursing were integrated into Higher Education (Burke 2006a).

The transition into higher education from hospital-based schools of nursing emphasised the academic preparation of students by granting them a supernumerary status. The supernumerary status ensured that the names of students were no longer included on the duty roster and were not calculated in the number of staff required for the delivery of patient care (UKCC 1986). This move was considered an essential requirement for student nurses to develop the necessary academic skills and knowledge that underpinned contemporary practice (Slevin 1992). Students were given time to develop a more reflective account of their practice experiences and to

seek out learning opportunities that had been previously foreclosed to them due to work constraints (UKCC 1986). This move transformed the role of student nurses from being ‘apprentices’ within the organisation to that of university students who were on a work placement that accompanied their studies. Following this change, some confusion about the role and status of student nurses led to some qualified nurses feeling that the student’s new status could disrupt the existing social structure within the clinical setting, in which the primary concern is on ‘getting through the work’ without the burden of supervising the supernumerary students (Hyde and Brady 2002). However, students reported that the supernumerary status helped to mitigate against the *anticipatory anxiety* that they experienced when being placed in new and unfamiliar practice environments (Gray and Smith 1999). Furthermore, a mismatch in the perceptions of the student status was reported by (Allan and Smith 2009) whereby student nurses claimed to feel ‘stigmatised’ by qualified nurses who perceived that they undervalued the ‘bedside components’ of nursing practice.

In 1994 the UKCC published guidelines for nurses who wished to perform extended roles that were not traditionally associated with nursing (being previously undertaken by medical practitioners). *The Scope of Professional Practice* (UKCC 1994) outlined the need for nurses to be equipped with knowledge and skills that supported the safe practice of these roles. The expanding scope of professional nursing practice had coincided with a reduction in the number of hours that junior doctors could legally work. The European Working Time Directive had limited doctor’s hours to an average of 48 hours per week (EU 1993). With fewer junior doctors available to undertake tasks such as Venepuncture and Intravenous drug administration, nurses were being trained to perform these tasks in the doctor’s absence (Land and

Castledine 1996). Prior to the publication of the *Scope of professional practice*, training for these tasks had been ad hoc and subject to variation across the UK (Jowett et al. 2001). The extension of nurses' roles therefore provided a way of optimizing the skills and contribution of nurses, however, the move was viewed by some commentators as simply as a means by which nurses could 'plug gaps' in the shortage of available junior doctors (Autar 1996, Land and Castledine 1996).

2.1.5 The transition to an ‘all-graduate’ profession

Undergraduate nursing programmes have existed in the UK for over half a century, but they were initially only offered in a small number of institutions. The first such programme was commenced in Edinburgh University as a degree in Nursing Studies in 1960. However, the practice of nursing was not itself a central component of the degree award itself until 1967; the degree being primarily concerned with the theoretical aspects of nursing (Brooks 2011). Since 2013, all pre-registration nurse education programmes in the UK have been required to prepare students to graduate level prior to entry on the Nursing and Midwifery Council’s (NMC) Register; a mandatory requirement for practicing as a professional nurse in the UK.

The proliferation of HEI’s offering degree programmes in nursing across the UK opened up a debate about the academic level of education that is required to function as a nurse. The transition from apprenticeship-style training to undergraduate education reflected a broader change to the profession. The expansion of the roles undertaken by nurses, an increasing use of unqualified Healthcare Assistants, and the ongoing shortage of registered nurses in the UK meant that nurses had to become ‘knowledgeable doers’ so that a perceived gap between nursing knowledge and nursing practice could be closed (Basford and Slevin 2003, Macleod-Clark et al. 1997). These reforms to nurse education and the changing role of the nurse prompted a suggestion that this ‘new generation of nurses’ were “Too posh to wash” (see Appendix 1 – Daily Mail headline “Too clever to care”). This trope became widespread following a debate of members at the Royal College of Nursing Congress in 2004. The motion tabled at this debate, questioned whether some of the

more traditional 'beside tasks' associated with nursing should be delegated to unregistered carers. The motion was soundly rejected at the conference, but this apparent concern about the changing role of the nurse nevertheless caught the imagination of the public news media (Young 2004).

The concern that nursing had lost sight of its core values initiated a debate that polarised nurses, nurse leaders, government ministers, news media and the general public in a debate about whether there was a necessity for nurses to be degree-educated, and about how they should be educated. One commentator argued that the university culture disrupted the development of nursing's professional identity which might impact on students' professional behaviour in practice (Castledine 2003b). Throughout these debates, nursing's past was represented by the British media as a 'golden era' that was being eroded by changes to nurse education. This representation of the changes to nurse education was described as an idealised and nostalgic view of the past that might only serve to have negative consequences with regards to public and future direction of the profession (Gillett 2014, Chatterjee 2005).

2.1.6 The current structure of Nurse Education Programmes

Nurse education programmes in the UK since 2013 have prepared students for practice through an undergraduate curriculum that is implemented in HEI's, under the regulation of the NMC. The current Standards for Pre-registration Nursing Education (NMC 2010) were based upon four competency frameworks for Adult nursing, Children's nursing, Mental Health nursing and Learning Disabilities Nursing, in addition to a generic competency framework. Each framework is based around Essential Skills Clusters (ESC's) which highlight five specific domains of practice to be achieved by each student. These ESC's are set out as guidelines upon which each HEI develops its own curriculum (see Table 2-2). Within each ESC are three progression points (occurring at the end of each academic year in most 3-year programmes) that are denoted by specific competencies to be assessed.

Care, compassion and communication
Organisational aspects of care
Infection prevention and control
Nutrition and fluid management
Medicines management

Table 2-2 NMC Standards for Pre-registration Nursing Education Essential Skills Clusters

Although the student nurses are not entered onto the professional register until completion of all assessed competencies, the NMC standards state that all student nurses are required to adhere to the NMC Code of Conduct (NMC 2015); they are

therefore obliged to adopt the behaviour of a professional nurse and to act within the Code's professional boundaries. From the outset of the undergraduate programme, nurses adopt the status of professionals and act in accordance with professional values. This, the NMC suggest, will inspire confidence in the public that all members of the profession (including students) will act with professionalism and integrity and provide high quality, safe practice (NMC 2010).

Over the 3 years of the undergraduate programme, students are exposed to both theoretical and practice-based learning. A total of 4600 hours of learning is required to meet the requirements for entry onto the professional register. This learning is divided into 2300 hours of practice and 2300 hours of theory. Up to 300 hours of the practice learning can take place in simulated learning environments, with a minimum of 2000 hours of direct patient contact experience. The structure of the undergraduate nursing programme therefore necessitates that the student must fulfil the academic requirements of an undergraduate programme in addition to accumulating the requisite hours of practice and the achievement of all practice competencies. The intensity of the programme has been cited as a potential factor explaining a UK national average attrition rate of 20% amongst undergraduate student nurses in comparison to approximately 12% in other undergraduate programmes (Willis 2015, Bayliss-Pratt and Smith 2015).

NMC standards describe a foundation upon which each HEI is able to develop their own curriculum to facilitate the students' progression towards graduation and entry onto the register. All curricula are ratified and audited by the NMC to ensure

compliance to the prescribed standards to ensure that there is consistent delivery across all HEI's. Therefore, although students at all universities will be assessed against the same competency standards, each HEI will operationalise these assessments in accordance with their own university assessment regulations. The NMC provide *Standards to Support Learning and Assessment in Practice* (SLAiP) (NMC 2008) set out the processes by which students are supported in their learning and how they are assessed in practice. These standards require the student to work with a mentor in practice placements. The mentor is a registered nurse who acts as the facilitator of learning experiences and as assessor of competence. The mentor is expected to identify opportunities for the student to practice and encourage reflection on experience. The effectiveness of the mentor to support learning in practice has been reported to reduce students' stress and to enhance socialisation processes (Ousey 2009, Rejon and Watts 2014) and underpins all clinical practice experience that the student nurse is exposed to over throughout the programme.

2.1.7 The epistemological development of nursing

In this section, the history of the nursing profession will be presented alongside its epistemological development to reveal the way in which professional knowledge has been influenced by social and political changes (see Table 2-3). From its early days of professionalisation, nursing has been associated with a strong sense of duty and service to its patients. Florence Nightingale's project of setting out normative values, behaviours and dispositions within the nursing body has endured to a large extent; it still forms the basis of regulatory statements arising from the NMC. It was only at the time of the introduction of state examinations that we first see a formalisation of knowledge required for professional nursing practice. Entry onto the professional register became selective only to those who demonstrated that they possessed an appropriate level of knowledge, in addition to an appropriate attitudinal predisposition. Nursing textbooks of the time emphasised procedural knowledge to complete bedside tasks such as bandaging and preparation of inhalations and poultices (c.f. Harmer 1926). What can be ascertained about nursing during that era is that nurses were expected to be dutiful, efficient in the application of medical treatments, and knowledgeable about preparing the sick room (D'Antonio 2002). Physical assessment was only performed in a limited capacity, and changes to the patient's physical condition were reported to a senior nurse or doctor rather than being acted upon (Capparelli 2005, Chatterjee 2005).

The fundamental shift that occurred in the nursing profession during the mid-part of the 20th century, has had the most profound effect upon nursing's claim to a unique body of knowledge. The development of the theories of nursing and empirical

research to describe its goals, allowed the profession to begin charting its own course towards becoming the body of autonomous, independent and critical decision-makers. The precise reason for the timing of this point of departure appears to be a consequence of wider social and political forces. The inception of the NHS, changing perceptions of women's role in the workforce and access to professional education, widening healthcare needs of the population, and the desire to articulate nursing's contribution to health care, all occurred at around the same time (Abel-Smith 1975, Davies 1980, Dingwall et al. 1988, Fletcher 1997). The development of nursing science and attempts to define caring as empirical science sought to place nursing as an academic discipline in its own right (Smith 1990, Watson and Smith 2002). Subsequently, this initiated and facilitated the transition of nurse education into HEI's towards the end of the 20th century.

The Nursing Process became a ubiquitous concept in both nurse education and in professional clinical practice at a time when nurses were beginning to take on roles that had traditionally only been performed by doctors. Again, political changes to the availability and hours worked by junior doctors expanded the scope of professional nursing practice. With the subsequent reduction of a medical presence in clinical areas came a requirement that nurses possess the capacity to make autonomous decisions about the care needs of their patients. The broad range of professional knowledge required by practising nurses now included, not only all that which had been required beforehand, but also included skills in advanced assessment, planning, implementation and evaluation (Schultz and Meleis 1988). Documentation of nursing care was separated from medical notes and nurses needed the necessary skills to articulate care decisions to other members of the multidisciplinary team.

The movement of nurse education out of hospitals and into HEI's appears, to some observers, to be another fundamental point of departure for the profession. However, given the transformations to nurse education (and the profession as a whole) in the previous decades, it could be argued that this was an inevitable consequence of the expanding range of knowledge and skills required to deliver competent nursing care. Although the profession may still be orientated towards a vocational disposition, there is an increasing need for generic, critical attributes to be taught to student nurses (McKendry et al. 2012). Notwithstanding this, external political and economic pressures have also necessitated a change to the funding arrangements for nurse education and healthcare delivery (Burke 2006a). Throughout nursing's history there has been a complex interrelationship between the internal struggles of a profession trying to develop its identity as a discrete discipline, and the external pressures applied to the profession resulting from political and social change.

Era	Historical milestone	Epistemological development
1860	Florence Nightingale establishes the first School of nursing at St Thomas' Hospital, London	Establishment of appropriate values, attributes and behaviours required by nurses
1919	Nurses Registration Act passed in Parliament- Voluntary registration	Formalisation of nursing as a professional body. Regulatory powers used to establish entry criteria for the profession based upon knowledge acquisition.
1921	Formation of the General Nursing Council	
1925	First state examinations for entry to register	
1943	Nurses Act passed in Parliament- Mandatory registration; establishment of Second Level nurse (SEAN)	Division of labour based upon different levels of knowledge required to practice.
1948	Formation of the NHS	Broader scope of knowledge required to treat patients whose needs had previously been unmet under a 'paid for' healthcare system.
1950-1970's	Development of nursing science, models and theories of nursing.	Establishment of a unique body of nursing knowledge, distinct from other healthcare professionals. Articulation and empirical description of nurse's contribution to health care.
1977	Description and implementation of the Nursing Process	Nursing knowledge includes critical thinking, independent decision-making and separation of nursing care from medical orders.
1986	Project 2000	Transference of education to HEI's. Mandatory minimum education to diploma level. Supernumerary status of student nurses to facilitate critical reflection on practice
1992	Scope of Professional Practice (UKCC)	Expansion of nursing knowledge. Mandatory assessment of knowledge underpinning skills for extended practice.
2012	All-graduate entry onto the professional register	Internal and external conflicts about the nature of nursing knowledge and the knowledge requirements for nursing practice.

Table 2-3 - Epistemological milestones in Nursing

2.2 Theoretical perspectives on Identity

Identity can be broadly understood to describe to the way in which human subjects are identified- and identify- themselves. This identification can originate from our own characteristic way of acting, the relationships that we have with other people, and how others react to us (Miel et al. 2002). It can also been described as a concept that embodies our sense of uniqueness as individuals and as members of groups (Taylor and Spencer 2004). Identities can be based upon the ideologies that are connected to various defining elements of our lives: political allegiance, nationality, gender, or occupation (Giddens 2009).

Benwell and Stokoe (2006) describe the theoretical development identity in terms of paradigm shifts occurring from the sixteenth century onwards. They divide the accounts of identity as falling into three categorisations:

- 1) *The project of self*- in which individuals are self-fashioning and agentive;
- 2) *Social and collective identity* – extending the formation of identity from the individual to the social;
- 3) *Constituted in discourse* – a post-modern view of identity that is fluid, fragmentary and contingent.

These three theoretical positions can be placed on a continuum between individual agency and social structure (see Figure 2-2). The agency that an individual has over the way that they behave, are capable of making choices, and present themselves to others, defines the key differences in these theoretical positions. At one end of the continuum, the individual can act independently and make free choices and

possesses a self that is stable and fixed (Agency). The individual is free to present themselves in any way and that their identity is a matter of free will. At the other end of the continuum, the individual is constrained by social factors that are imposed upon him by social structure. These influencing factors might be arbitrary categorisations based upon gender, class, religion, ethnicity (Duff 2012, Erikson 1968, Hogg 2006). This is a structuralist viewpoint that assumes that the notion of individuality is somewhat illusory and that members of society internalise the norms, values and behaviours of social life and conform to them; negating any real sense of independent choice (Block 2013, McGowan 2006). Lying between these two extremes are theories that imply a dialectic between the self and society. The individual is cognisant of the social norms that are being enforced upon him and can negotiate a balance between self-determination and socially determined behaviours. Burr (2015) describes how these opposing perspectives on agency relate to the theoretical positions of micro constructionism and macro constructionism within the general field of social constructionism.

Sociological and social psychological theories that can usefully illuminate the concept of identity are: Symbolic interactionism (Mead 1934, Blumer 1969); Social Identity Theory (Tajfel 1974) and Social Constructionism (Berger and Luckmann 1967). These theories assume identity to be the product of: self-determined cognitive processes; relationships and interactions within society; and socially constructed accounts of reality, respectively. Each of these theories has a unique perspective and offers different methods for explaining and exploring identity. The following sections explain how each of these three theoretical perspectives can define the concept of identity.

2.2.1 Social psychological theories of Identity

Psychological theories view identity as being inherently personal constructions of who we are (our self-perception) (Howard 2000). In other, more socially orientated psychological theories- in which the individual is in constant interaction with the external world- identity is referred to as us knowing not only who we are but who we are not (Kroger 1993). Our perception of ourselves, and comparisons of ourselves with others, create challenges to our self-concept from which we reflexively transform ourselves (Miel et al. 2002). A core identity is said to exist, from which we make connections to the social world through the lens of our self-perception (Turner 1986). It is through these connections, that core identity is transformed and adapted (Johnson et al. 2012). In his *Psychosocial Theory*, Erik Erickson contended that identity consists of a “conscious sense of the individual uniqueness and an unconscious striving for continuity with a group’s ideals” (Erikson 1968:p 208). Psychosocial theory emphasises the need for continued connectedness between the self and the social; identification of the individual requiring an interaction with a broader social identity. He described the *normative crises*, that can occur when discontinuities and conflicts arise between self and group norms and ideals, that are essential for human development. Social psychological theories of identity therefore consider the individual and the social world to be interrelated but discrete; the individual must know his/her world in order to develop a sense of identity but remains separated from it (Marcia 1994). This duality between the self and the social defines the key difference between psychological identity theory and other more socially orientated theories (Waterman 1999).

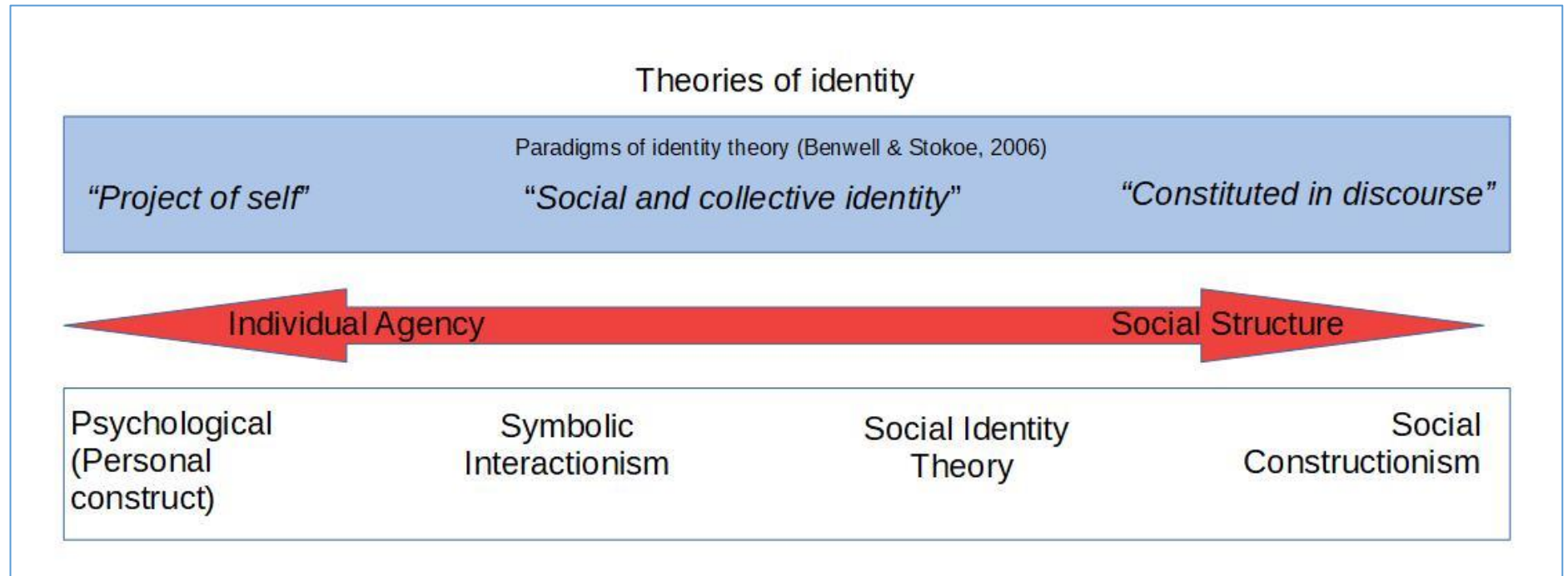


Figure 2-2- Paradigms and theories of identity

2.2.1.1 Symbolic Interactionism

Symbolic Interactionism is an approach to the study of human experience that was developed from the work of George Herbert Mead by the American Sociologist Herbert Blumer in the 1960's. Blumer's Symbolic interactionism is based upon 3 premises. The first premise is that human beings act toward things on the basis of the meanings that those things have for them. These might be physical objects or other human beings; individually or organised into groups and institutions. The second premise is that these meanings are derived from social interaction that humans have with one another; they are co-created. The third premise is that meanings are managed and modified through an interpretive process used by the individual through their dealings with the things that they encounter (Blumer, 1969). This approach was developed with the intention of building an objective science of human conduct that could conform to the criteria borrowed from the natural sciences (Denzin, 1992). Symbolic Interactionism's orientation towards co-creation and negotiated meaning lends itself well to explorations of group identities. Where that group is set in the professional context (such as nursing), the appropriateness of Symbolic Interactionism to the study of professional socialisation has a good theoretical fit and has been used in several studies of professional identity (DI Deppoliti 2008, Keeling and Templeman 2013, Miro-Bonet et al. 2008, Ware 2008). However, Symbolic interactionist studies have been criticised for failing to attend to the affective and unconscious aspects of human behaviour (Meltzer et al. 1977). For symbolic interactionists, the influence of emotion on the perception of the self and of others, or of unconscious behaviours, are rarely considered to be important components of human interaction in the construction of social life (ibid).

Development of professional identity might (at least in part) occur at an unconscious level, and be influenced by emotional reaction to experience, therefore should remain a part of the analysis until this is found not to be the case.

2.2.2 Social Identity Theory

In Social Identity Theory identity is conceptualised as being a product of our affiliation with other individuals who are perceived to have similar characteristics and social status as ourselves (McKinlay and McVittie 2008). Social identity theory (SIT) can be a useful way of analysing organisations and social groups, particularly with regards to the categorisation of groups and the resulting group behaviours (Ashforth and Mael 1989). The formation of groups from individuals who share similar attitudes and beliefs create a set of behaviours and norms which are used to define and create cohesion within the group, and to provide a reference for which others can be excluded (Ashforth and Mael 1989, Willetts and Clarke 2014b). Tajfel and Turner (1986) describe how *Ingroup* and *outgroup* behaviour develops from social group membership; a feeling of solidarity and unity with those within the group (ingroup) and rejection and marginalisation of those outside of the group (outgroup). Social group membership provides a stable social identity that allows individuals to identify with those others with whom they feel that they belong. This behaviour is considered to be essential to provide the individual with a sense of self-worth and to create a connection between the individual's identity and the identity of the social group (Hogg 2006).

The group membership of an individual as a framework for understanding the formation of professional identity in nursing is an appealing one as it is based upon a shared understanding about the role and function of the professional group.

However, nursing care is, by nature, diverse, subjective and encompasses a wide range of activities. Therefore, any arbitrary definition of such a group role and

function becomes problematic. Whilst it can be assumed that student nurses intend to become a member of the professional group (by virtue of their entry to the undergraduate programme), there is a tacit assumption that the student, and the profession as a whole, share a common sense of what this group identity is and how nursing is defined, which might not be the case.

2.2.3 Social Constructionism

Theories of identity described thus far have arisen from the psychological disciplines and have assumed that there is a generally accepted view of nursing from which the individual shapes their own sense of identity (Clouder 2001). Social constructionist theories, however, have their ontological foundation in the notion of a subjective and contingent reality; of which implicit assumptions and ‘taken for granted’ views of a profession are the product of ideology and power (Benwell and Stokoe 2006, Fairclough 2010). Social constructionists view identity as an element of a subjective reality that is held in a dialectical relationship with society (Burr 2015). Therefore, identity is formed through (and by) social processes, and once this identity has been crystallised it can be maintained and modified through social relations (Berger and Luckmann 1967). As with social identity theory, the individual and society are intertwined, but the key difference between these two theoretical approaches is in the nature of the relationship between society and the individual. The Social constructionist view is that identity is a social phenomenon and is unintelligible unless it is located within a more generalised interpretation of social reality (Andrews 2012, Burr 2015, Berger and Luckmann 1967); and this interpretation is both subjective and contingent. The social constructionist view is that the professional person is an analogue of practices that perform ideological work in the service of society (Douglas 2012). As a result, the structure of the professional socialisation process is externally defined by others, and related to tacit social practices that shape the emerging professional identity (Clouder 2001). Given the discussion about nursing’s evolving epistemology as an analogue of its social function (Section 2.1), Social Constructionism offers a compelling approach to the

exploration of professional identity development; it allows the analyst to consider macrosocial influences that come to bear on the nursing profession, and on the students making the transition from lay person to professional.

2.2.4 Professional Identity

An individual's identity relates to a personal and social sense of being. One might have multiple identities related to various aspects of one's life (gender, nationality, sexuality etc) (Taylor and Spencer 2004). These identities are developed by individuals in the form of dispositions that occur in response to certain social conditions encountered by the individual. Pierre Bordieu theorised how these dispositions are a product of objective social structures (the field) from which the individual inculcates acquired schemes of perception, thought and actions (habitus) (Bordieu 1984). Subjectively internalising these perceptions develops a sense of identity in the individual (Bottero 2010). Professional identity might therefore describe an individual's sense of belonging to the professional group, or it might describe the outsider perspective of the professional group when encountering the profession (e.g. a patient or a student nurse entering the profession).

To understand professional identity, it is important to explore and define identity in the context of social and occupation roles that are fulfilled by being a part of a professional group. In this chapter, it has been shown how Symbolic Interactionist, Social Identity and Social Constructionist theories led to 3 different ways of conceptualising professional identity. The identity of a profession is closely related to, but remains distinctive from, Occupational identity. Occupational identity is a product of work-role definition and the individual's sociocultural need to fulfil a role in a functioning society (Kielhofner 2007). Furthermore, the purpose of possessing a strong occupational identity is to engender a feeling of occupational success, social adaptation and psychological wellbeing (Skorikov and Vondracek 2011).

Occupational Identity might be useful to describe the behaviours and social norms of specific workplace contexts, where the members of the occupation are concentrated into certain organisations. However, its utility becomes uncertain when the workforce is distributed across wider geographical and cultural contexts; as is the case with nursing. Moreover, the term profession might describe certain occupations but many occupations do not meet the criteria of being a profession (MacDonald 1995:p 2). A profession can be defined in many ways but certain criteria have become commonplace, particularly: the possession of a unique body of knowledge; provision of an altruistic service to society; and autonomy over work, and work conditions (Liaschenko and Peter 2004). The term *professional identity* therefore describes how the members of an occupational group are perceived- by themselves and by others- to be able to fulfil and maintain these criteria. As such, professional identity is a statement of how an occupational group is perceived to hold authority over: its knowledge claims; its function in the context of the society it serves; and its self-determined aims and objectives.

The extent to which nursing is founded upon unique knowledge might be questioned, considering the history of professionalisation in nursing (as described in section 2.1.1). Between the legal statute of nursing's professional status in 1919, and the early developments of nursing science in the late 1950's, nursing knowledge was indistinct from that of the medical profession. Alongside this inherited knowledge there existed a lack of authority that nursing had over its work role; being ancillary to the medical profession. It was not until the development of a Nursing Process (through the mid to late 20th century) that autonomous practice is first recognised. However, professional identity is not simply a descriptor of whether nursing

achieves the criteria of a profession but, instead is the extent to which nurses are perceived to be identified with that criteria.

In contemporary nursing practice, nurses are provided with education that is underpinned by the profession's unique knowledge claims, they fulfil autonomous roles in nurse-led services, and are subject to the conditions set out by a nurse-led regulatory body (NMC). However, being a professional nurse is frequently defined in ways that transcend these objective criteria; by reference to subjective moral and ethical values, individual attributes and emotional constitution. Thus, professional identity in nursing is described in terms of 'who nurses are' and not just 'what nurses do'.

2.3 Summary

The history of nursing's epistemological development highlights how the nursing profession has reflexively adapted to changing social conditions. The profession's response to political and economic circumstances, and the ever-changing healthcare needs of the population, exemplify nursing's role as a public service. The status of the profession has undergone radical changes since its professionalisation. The changes to the role and function of the nurse have been mirrored by adaptations to nurse education programmes. The transition into an era where the mandatory requirement for graduate entry onto the professional register has been punctuated by a number of developmental steps in which nursing has made claims to a unique body of knowledge. Furthermore, the identity of the nursing profession is charted by the transformation of nurses from being identified as 'angels' through to a more contemporary image of the nurse as a 'knowledgeable doer'. Contemporary professional practice still possesses many of the key characteristics that are perceived as essential requirements of nursing care. The ethical, moral and emotional dimensions of nursing the sick have endured over time despite changes to the scope of the nurse's role.

A broad range of research and scholarly narratives have been published regarding the socialisation of nurses and the processes by which nurses develop and maintain their professional identity. The theoretical approaches discussed all offer a different perspective on the nature of professional identity and the processes by which it is developed. Where a high level of individual agency is assumed, identity is said to be a product of conscious, self-determined and deliberate actions. Where identity is

assumed to be a product of social structures, the processes are assumed to originate from the broader social influences that are disseminated and reproduced through discourse. In the former, professional identity is an individual's sense of being, in relation to their membership of a professional group. In the latter, professional identity assumes a way in which the whole profession is presented to the world and is shaped by powerful social influence through discourse.

There is a complex network of competing and conflicting ideas about professional identity and what it actually tells us about the nursing profession. Depending on how professional identity is defined, the processes by which it is developed will differ. A more lucid account of the social influences that shape the contemporary professional identity of nursing is required if the profession is to strengthen its own position in the determination of its future direction.

3 Literature review on professional identity in nursing

A preliminary literature review was undertaken during the development of the research proposal for this study to identify the existing literature on the subject, to justify the purpose of the study and to claim the theoretical position that it would occupy. This literature review was updated at the latter stages of the study to include recent literature that had been published during the time that the study had been undertaken. This chapter describes the systematic search of the literature that situates the study in the context of the existing literature on professional identity in nursing. Identity is a broad concept that crosses many disciplinary boundaries, but this review retains its focus on nursing scholarship, so that any specific characteristics of nursing identity could be elucidated.

Charmaz (2014) emphasised the role of the literature review in constructivist grounded theory research as being primarily concerned with locating and justifying the theoretical framework that is being used to develop the grounded theory. The primary purpose of this literature review was threefold. Firstly, it aimed to reveal the ways in which the literature defined the concept of identity in the context of professional nursing; its defining characteristics and the origins of its underlying assumptions. Secondly, the review attempted to describe the theoretical frameworks that has been explicitly and implicitly used to study the concept of professional identity in nursing. Finally, to uncover the processes of professional identity formation that were described in the literature. This review of the literature was not intended to specifically critique the research studies themselves, or to examine the rigour with which the studies had been undertaken. A more general aim of the

literature review was focused upon gaining an understanding about the assumptions that had been made in the studies' research designs and in the subsequent conclusions that were drawn. Therefore, critique of the literature is focused on the theoretical assumptions that formed the foundation of the research design. The purpose of this review is to provide an insight into the way that the discourse of professional identity in nursing has been reproduced in the literature; outlining the ways in which the field of inquiry has been approached epistemologically, and the ontological assumptions made. By identifying the theoretical frameworks and conceptual definitions used in existing research, this current study can be situated among other similar studies. In doing so, the study's purpose is justified, and its originality established.

3.1 Literature reviews in grounded theory research

The timing of literature reviews in Grounded Theory research is the subject of debate among scholars of grounded theory. The ‘classic’ approach to Grounded Theory, as originally described by Glaser and Strauss, emphasised the importance of the researcher entering the field of study without preconceived ideas of the knowledge that might be ‘discovered’ within the data (Glaser and Strauss 1967). This required the researcher to delay the literature review until the data had been collected, analysed, and when a theory (grounded in the data) had been generated. The justification for this delay was to ensure that the researcher did not view the data through the lens of earlier ideas or that these preconceived ideas might be imported into the current work (Kelle 2005, Charmaz 2006, Charmaz 2014); emphasising a process of discovery rather than reinforcing or testing existing knowledge and ideas.

Similarly, the extent to which a researcher might enter the field of inquiry without pre-existing knowledge, perspective or experience of the subject under investigation, has created dispute among grounded theorists. In its original form, the Grounded Theory Method requires the researcher to be a ‘blank canvas’ when entering the field; it assumes that any theory that emerges from the data must be uncontaminated by a priori knowledge so that data is not ‘forced’ into categories that originate from existing studies (Denzin and Lincoln 2013, Glaser and Strauss 1967). However, with such ‘naïve empiricism’ the researcher risks overlooking prior theoretical and research literature that could be a source of inspiration, ideas, creative associations and critical reflections (Thornberg 2012), or could result in the rehashing of old empirical problems or dismissing the literature (Charmaz 2014). An informed

approach to Grounded Theory is utilised in Constructivist Grounded Theory. Prior knowledge and extant theory are not seen as problematic or a source of potential weakness in the theory that is developed from the data. Instead, the Constructivist Grounded Theory approach recognises the researcher's embeddedness within the historical, ideological and sociological context in which the study takes place (Bryant and Charmaz 2007, Charmaz 2006, Charmaz 2014, Charmaz and Thornberg 2011). Data therefore represent social constructions rather than objective views of reality and cannot be separated from existing knowledge (Thornberg 2012). From the Constructivist Grounded Theory perspective, a literature review can be legitimately performed ahead of the analysis of data and the generation of a theory grounded in it because it enables the researcher to engage with existing ideas, critique and refine existing categories and set the study into a broader context of knowledge about the subject.

3.2 Literature Search Methods

The overall aim of the literature review was to understand how theories of identity have been used to frame existing research about the nursing profession. More specifically, it sought to reveal the conceptual definitions used and the theoretical assumptions made by the researchers of professional identity among pre-registration undergraduate student nurses. This was undertaken with the following objectives that orientated the literature review:

- Review existing literature that explores identity and professional identity formation among undergraduate pre-registration student nurses.
- Identify the explicit and implicit theoretical assumptions about identity and identity formation upon which the studies are based.
- Outline current understanding of the processes involved in the development of professional identity in preregistration undergraduate student nurses.

3.2.1 Literature search question

This literature review explores the existing literature about professional identity in nursing and how undergraduate pre-registration student nurses develop their sense of identity. Much of the literature that has been published thus far has been concerned with the socialisation of nurses during the pre-registration period and immediately after qualification (c.f.Melia 1987, Bradbury 1990, Du Toit 1995, Fitzpatrick 1996, Fletcher 1997, Howkins and Ewens 1998, Mackintosh 2005, Ousey 2009, Zarshenas et al. 2014). By reviewing the existing published literature, clarification of the ways that the process of developing a professional identity has been conceptualised is gained. Therefore, as a result of this review, the gaps in the current understanding of this phenomenon can be identified. Literature was searched to answer the following questions:

- 1) What is meant by professional identity in nursing?
- 2) What philosophical and theoretical assumptions are made in the studies that explore this concept?
- 3) What processes are attributed to the development of professional identity in nursing?

To frame these questions in a format that could facilitate a systematic search of the literature, a PEO framework was used to clarify the search question and subsequent database search. The PEO framework enables the formulation of a search question and to identify the key concepts in the question (Betanny-Saltikov 2012). The PEO format and its application to this literature review is described in Table 3-1. The framework allows for interpretation in the ways in which the concepts are categorised in terms of Population, Exposure and Outcome. The application of this

framework allowed for the clarification of the concepts being considered in the literature review: Undergraduate student nurses (population); professional development/socialisation (exposure); professional identity (outcome).

P	Population Patient Problem	Who are the users- patients, family, practitioners or community being affected? What is the setting?	Undergraduate Pre-registration Nursing Students
E	Exposure	Exposure to a condition, illness, a risk factor or service.	Formation and development of professional, learning and socialisation.
O	Outcome or themes	Experiences, attitudes, feelings, improvement.	Professional nursing identity.

Table 3-1 PEO Framework applied to the literature search question

3.2.2 Facet Analysis

To develop a list of search terms and key words for the electronic database searches, a Facet Analysis was performed. Using an online Thesaurus and by noting related terms from other literature on identity in nursing, alternative search terms were identified. This procedure ensures that a comprehensive search of the literature can be completed where there are multiple related terms that describe the same (or similar) concepts. Associated terms were searched, and the content of the studies were manually reviewed to ensure that all relevant literature was included, and that unrelated literature was excluded prior to analysis.

Table 3-2 shows the related facets of the concept of identity and the associated keywords used in the search. These keywords were then searched using the OR operator. Each Facet was searched using the AND operator.

Identity	identit*
Identities	
Self-Identity	self-ident*
Self-Concept	self-concept*
Formation	form*
Construction	construct*
Development	develop*
Socialisation	socialis*
Socialization	socializ*
Learning	learn*
Learn	
Nursing	nurs*
Nurses	
Student	student*
Preregistration	prereg*
Pre-registration	pre-reg*
Undergraduate	undergrad*
Under-graduate	under-grad*
Professional	profession*
Profession	

Table 3-2 Facet Analysis for Literature Search

The completed search string using all of the facets and the appropriate operators is shown in Table 3-3.

identit* OR self-ident*
AND
form* OR construct* OR develop OR socialis* OR socializ* OR learn*
AND
nurs* OR student* OR prereg* OR pre-reg* OR undergrad* OR under-grad*
AND
Profession*

Table 3-3 Database Search string with operators

3.2.3 Inclusion and exclusion criteria

Professional identity is a concept that is broad and has been explored in a wide range of contexts. To ensure that only the most appropriate literature for the review was used for the review, a set of inclusion and exclusion criteria were applied to the literature search results. A range of published studies that explored the concept of professional identity in the same context as that of the current study were sought.

These studies had to fulfil the following requirements:

- The subjects under investigation had to be studying nursing at undergraduate level.
- The students had to be enrolled on a UK nursing programme
- The curriculum upon which the programme was based should be (as far as possible) founded upon the same criteria.

Prior to the mandatory requirement by the NMC for all pre-registration nurse education to be delivered via undergraduate programmes, Universities offered diploma and Advanced Diploma programmes. All students enrolled on these programmes were given the title of Student Nurse despite the differences in the curriculum between undergraduate and diploma programmes. Programmes commonly used separate assessments for theoretical and practice competencies. The impact on the students' professional identity formation- that these different curricula might have- cannot be easily ascertained. Two research sites were to be used in the current study. Both had established an all-graduate curriculum for pre-registration nursing programmes several years prior to the time that the study commenced.

Therefore, the studies selected for the review also needed to be performed using under-graduate student nurses as the subjects of their investigations.

Nurse education in the UK is delivered under the governance of the NMC. The Standards for Pre-registration Nursing Education are developed by the NMC and all UK nursing programmes are ratified and audited to ensure consistency. Universities are able to develop their own curricula that incorporate these standards, but consistency should be evident across all UK programmes. Non-UK nursing education programmes would therefore be founded upon standards that are laid out by their respective regulatory boards and might not emphasise the same standards of professional behaviour or prepare students for a different nursing role; potentially resulting in professional identity that is dissimilar to that found in the UK. For this review, only studies that included students enrolled at UK higher education institutions were included in the review. Similarly, within the UK there have been periodic changes to the curricula as a result of updated standards for pre-registration nursing education, as set out by the NMC. A fundamental change to UK nursing education occurred following the inception of the Essential Skills Clusters (ESC) in 2007. This broad set of competencies underpinned the nursing curriculum and were based upon the revised Code of Professional conduct (The Code) that was published in 2008. Whilst the Code has since been updated in 2015, the ESC remains a constant framework upon which all UK undergraduate nursing programmes are based. Therefore, to ensure (as far as possible) that the student nurses that participated in the studies chosen for the review were all undertaking similar programmes of study, only studies that were published from 2008 onwards were

included in the review. Table 3-4 shows the inclusion and exclusion criteria for the filtering the literature search results.

Inclusion and Exclusion criteria for the literature search		
Inclusion	Exclusion	Rationale
Primary research	Non-research-based papers (unsystematic reviews, discussion papers or editorials)	To identify primary research in this field of inquiry.
Studies undertaken in the UK	Non-UK studies	The culture and education processes in non-UK countries might be different.
Studies undertaken within the last 9 years (2008-2017)	Studies where data was collected before 2008	The establishment of the current standards of nursing education- that might underpin the identity of nurses- were implemented from 2008.
English language studies	Non-English language studies	Foreign language studies require translation facilities that were unavailable.
Studies that include a definition of identity as it was conceptualised in each research paper	Studies that do not define the concept of professional identity within the study.	Suggests weak theoretical foundation to the study or that the concept is assumed to be understood.
Examine the processes by which professional identity is developed or described by nurses.	Does not address the formation of professional identity or describe nurse's perceptions of it.	The area of interest in this review is the development of professional identity.

Table 3-4 Inclusion/Exclusion criteria for literature review

3.2.4 Databases searched

The keywords from the Facet Analysis were searched using three Electronic databases. Table 3-5 shows the databases included within the search engine, along with descriptions of the literature included in each. The keywords were searched individually and with the search string operators so that a grid of results could be created (Table 3-6).

Database	Details of literature included
EBSCO- Education Abstracts	Education database of abstracts from more than 680 periodicals and yearbooks from 1983 onwards.
CINAHL- Cumulative Index of Nursing and Allied Health Literature	An index of over 5000 journals for the field of nursing and allied health literature.
Medline	Database with an emphasis on clinical medicine but also includes nursing, healthcare delivery and social sciences.

Table 3-5 - Databases searched for literature on identity

Following the search, results were reviewed for title and abstract so that the inclusion/exclusion criteria could be applied. Search results were manually reviewed for relevance to the search question and duplicates were removed. After these exclusion criteria were applied to the initial search, the initial 172 papers identified were reduced further where the research had been conducted in other countries or being non-research-based articles. Following this procedure, 9 papers remained (see Table 3-6 for a breakdown of the search results by keywords used). Table 3-7 Shows a summary of the studies that were subsequently reviewed for the analysis.

Facet	Search string	Search results
1	identit*	304,630
	self-ident*	2,128
	self-concept*	17,290
	ident* OR self-ident* OR self-concept*	317,983
2	form*	162,311
	construct*	58,260
	develop*	441,083
	socialis*	688
	socializ*	5,032
	learn*	103,235
	form* OR construct* OR develop* OR socialis* OR socializ* OR learn*	657,036
3	nurs*	664,704
	student*	127,880
	prereg*	333
	pre-reg*	1,464
	undergrad*	12,669
	under-grad*	66
	Nurs* OR student* OR prereg* or pre-reg* OR undergrad* OR under-grad*	744,482
4	profession*	299,099
	Facet 1 AND Facet 2 AND Facet 3 AND Facet 4	172
	Results after applying inclusion/exclusion criteria and relevance checking	9

Table 3-6 - Database search results

Study title	Aims of the study	Research design	Key findings
<p>Professional identity as a resource for talk: exploring the mentor-student relationship</p> <p>Shakespeare. P and Webb. C. (2008) <i>Nursing Inquiry</i>. 15; pp270-279</p>	<p>To examine how mentors in nursing education make professional judgements about the clinical competence of pre-registration nursing students.</p>	<p>A Conversation Analysis of discussions between Undergraduate students and mentors.</p> <p>Sample- 15 mentor- final-year student dyads.</p>	<p>Conversations between mentor and student about every day encounters establish a professional identity.</p> <p>The mentor makes a judgement about the student's professional behaviour that is based on enthusiasm, indifference and confidence.</p> <p>Discussions about the student's behaviours in practice form the basis of the mentor's judgement about the student's professional identity.</p>

Study title	Aims of the study	Research design	Key findings
<p>Storytelling and professional learning:</p> <p>A phenomenographic study of students ‘experience of patient digital stories in nurse education</p> <p>Christiansen, A. (2011) Nurse Education Today. 23 (2011): pp289-293</p>	<p>To identify ways in which patient digital stories influence students’ professional learning.</p>	<p>A phenomenographic analysis of semi-structured interviews with 3rd year undergraduate students. 20 students were purposively sampled to discuss ‘digital patient stories’ that they had been shown prior to the interview.</p>	<p>Students reflected, made meaning and engaged emotionally during the discussion of patients’ narrative accounts of their care.</p> <p>From discussions with nurse educators, students generated new insights about their professional role.</p> <p>The authors report a potential for this process to develop a sense of professional identity.</p>

Study title	Aims of the study	Research design	Key findings
<p>Reconciling professional identity: A grounded theory of nurse academics' role modelling for undergraduate students.</p> <p>Baldwin. A., Mills. J., Birks. M., Budden. L. (2017) <i>Nurse Education Today</i>. Vol 59(1):pp1-5</p>	<p>To theorise a process of nurse academic role modelling for undergraduate students.</p> <p>To describe the elements that support positive role modelling by nurse academics.</p> <p>To explain the factors that influence the implementation of academic role modelling.</p>	<p>Qualitative grounded theory study across 2 universities (UK and Australia).</p> <p>Sample- 5 second year student nurses and 16 nurse academics.</p> <p>Data collection- Observation, focus groups and individual interviews.</p>	<p>Nurse academics must reconcile their own professional identity in order to role model professional behaviours for nursing students.</p> <p>Defines professional identity as how a person sees themselves in a professional role and how others view them, simultaneously.</p> <p>Relates professional identity to role definition of nursing in general.</p> <p>The occupational role enforces an identity upon the individual and that this identity has to be reconciled as the role changes.</p>

Study title	Aims of the study	Research design	Key findings
<p>Exploring commitment, professional identity, and support for student nurses.</p> <p>Clements.A.J., Kinman. G., Leggetter. S., Teoh. K., Guppy. A. (2016) <i>Nurse Education in Practice</i>. Vol 16:pp 20-26</p>	<p>To provide insight in the commitment of undergraduate student nurses.</p> <p>To explore how placement experiences might influence professional identity and hence retention of students on the programme.</p>	<p>Qualitative survey of 171 pre-registration student nurses and semi-structured interviews with 9 pre-registration student nurses.</p>	<p>Commitment to the profession strengthens professional identity.</p> <p>Reduced likelihood of attrition from the programme when commitment to the nursing profession is high.</p> <p>Recognises conflict in role identity between being a student and being part of the nursing team.</p>

Study title	Aims of the study	Research design	Key findings
<p>Professional identity in nursing: UK students' explanations for poor standards of care.</p> <p>Traynor, M., Buus. N. (2016) <i>Social Science & Medicine</i>. Vol 166 : pp186-194</p>	<p>To explore the factors that characterise the development of the professional identity of student nurses as they talk about experiences of clinical work in the UK NHS.</p>	<p>Qualitative study.</p> <p>Performed 6 focus groups with a total of 49 2nd and 3rd year BSc nursing students.</p>	<p>Identified a connection between identity and the values of the profession.</p> <p>Students recognised good role models by their demonstration of values that were aligned with their own.</p>

<p>Studying old masters of nursing: A critical student experience for developing nursing identity.</p> <p>Kelly, J., Watson. R., Watson. J., Needham. M., O'Driscoll. L. (2017). <i>Nurse Education in Practice</i>. Vol 26: pp121-125</p>	<p>To explore how student nurses develop critical professional identity through their reflections on nursing history.</p>	<p>Thematic analysis of 2nd year Student nurse reflections on a visit to the Florence Nightingale Museum in London, UK.</p>	<p>Students developed their sense of professional identity through learning about nursing's history.</p> <p>Critically reflecting on nursing's past reinforced commitment to the profession.</p> <p>Participants reported the conflict between their identity as students and the expectations of the public, and of healthcare organisations to meet certain expectations.</p>
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Study title	Aims of the study	Research design	Key findings
<p>The nurse-match instrument: Exploring professional nursing identity and professional nursing values for future nurse recruitment.</p> <p>Mazhindu. D.M., Griffiths. L., Pook. C., Erskine. A., Ellis. R., Smith. F. (2016) Nurse Education in Practice. Vol 18: pp 36-45</p>	<p>To identify the Key Quality Indicators (KQI) of an ‘excellent and ideal practicing nurse’.</p> <p>To evaluate the <i>Nurse Match</i> instrument as a recruitment and educational tool for the development of professional identity.</p>	<p>Qualitative analysis of data from Focus Groups. Voluntary purposive sample of: Qualified nurses (n=30), service users (n=10), post-graduate diploma nurses in mental health (n=25), 3rd year mental health student nurses (n=20) and adult and child health student nurses in years 2 and 3 (n=20).</p> <p>*This study was not excluded as it includes undergraduate students in the sample group</p>	<p>Explore applicant’s personal identity and values using a Values Based Recruitment (VBR) tool.</p> <p>These values were compared with those of the existing students, qualified nurses and service users with the ‘Nurse Match’ tool, to evaluate suitability for the professional role.</p>

Study title	Aims of the study	Research design	Key findings
<p>Finessing incivility: The professional socialisation experiences of student nurses' first clinical placement, a grounded theory.</p> <p>Thomas. J., Jinks. A., Jack. B. (2015). <i>Nurse Education Today</i>. Vol 35 e4-e9</p>	<p>To explore the impact of the first clinical placement on the professional socialisation of adult undergraduate student nurses in the UK.</p>	<p>Longitudinal qualitative study.</p> <p>Developed Grounded Theory from the analysis of diaries kept by undergraduate student nurses (n=26) during their first clinical placement.</p>	<p>Identified a conflict between the identity as a student and the need to 'fit in' as a part of the socialisation process.</p> <p>Socialisation viewed as a process of internalising values and behaviours that lead to a professional identity.</p> <p>Describes the negotiation of the students' sense of professional values when faced with practice that did not match their own.</p> <p>Students attempt to retain their status and identity as a learner.</p>

Study title	Aims of the study	Research design	Key findings
<p>An exploratory study: Student nurses' perceptions of professionalism</p> <p>Keeling. J., Templeman. J. (2013) Nurse Education in Practice. Vol 13: pp18-22</p>	<p>To explore final year nursing students' perceptions of professionalism using a reflective approach.</p>	<p>Phenomenological study of 1 focus group (n=5) and 5 individual semi-structured interviews.</p> <p>Participants were 10 final year under graduate student nurses.</p>	<p>Students develop a sense of professionalism and identity as a nurse from historical views of the profession in comparison to the observations of others during clinical practice.</p> <p>Students embraced nursing as a 'way of life' which impacts on their social being in conjunction with professional accountability.</p> <p>Role modelling of good and bad behaviour by practicing nurses was used by students to learn about professional behaviours.</p> <p>Students noted a dichotomy between the public perception of nurses and their professional responsibility to develop appropriate professional behaviours.</p>

Table 3-7 - Literature retrieved from database search

3.3 Analysis and Findings

All studies were downloaded as PDF files and entered into NVIVO 10 so that they could be coded in accordance with the questions being addressed. The studies were read and re-read to gain a sense of their theoretical assumptions and their conceptual definitions of identity. Some studies explicitly described the research approach and the theoretical positions underpinning them, others did not. In cases where there was no explicit statement made about the underlying theory that the study was based upon, the implicit theoretical assumptions about professional identity were noted.

The selected studies all addressed professional identity in nursing but did so in somewhat different contexts and with different aims. Overall, the studies all sought to gain a better understanding of the process of professional identity formation, but each with different objectives. For example, the inhibiting factors to developing professional identity were explored by some authors (Clements et al. 2016, Baldwin et al. 2017), whilst others sought to identify influencing factors (Kelly et al. 2017, Traynor and Buus 2016, Keeling and Templeman 2013, Christiansen 2011, Shakespeare and Webb 2008). However, all studies described some aspect of the process by which a student becomes a member of a professional group and the factors influencing that process.

3.3.1 Theoretical assumptions

The studies included in this review all adopted a theoretical framework (either explicitly or implicitly) with which they made claims about the development of professional identity. Those that did not explicitly make a statement regarding a theoretical position were considered, and an attempt to locate an appropriate position was made. From this first part of the analysis, it was noted that the studies were based upon 3 theoretical frameworks: Symbolic interactionism; Social Identity Theory and Social Constructionism (see Table 3-8).

Symbolic Interactionism	Traynor & Buus 2016 Thomas et al 2015 Mazhindu et al 2016 Keeling & Templeman 2013 Shakespeare & Webb 2008
Social Identity Theory	Clements et al 2016
Social Constructionism	Kelly et al 2017 Baldwin et al 2017 Christiansen 2011

Table 3-8 - Theoretical approaches used within the studies

These theories have a broad scope with regards to their utility in empirical studies; each theory has contested boundaries about which scholars have adopted differing positions for many years. The boundaries that define the difference in the theoretical approaches centre largely on the ideas held about the role of social structure and

individual agency. Agency has a role in the development of identity as it is responsible for an individual's ability to pursue their goals and regulate personal and social transformations (Duff 2012). Alternatively, social structure is a less precise concept that defines the role of powerful cultural, historical, social, institutional and political discourse that shape individuals (Block 2013). Social psychological theories- such as Symbolic Interactionism- assume a higher degree of individual agency in the production of knowledge and the meaning made of social phenomena (Meltzer et al. 1977). As such, it is held that the individual is conscious about how they define their own sense of identity; be it in terms of a self-concept or a professional identity.

Social Constructionist theories take a view that social structures are responsible for the production and reproduction of knowledge with individuals being subjects of socially derived meaning through discourse (Burr 2015, Blommaert 2005, de fina et al. 2006). There are several overlaps in the domains covered by each of these broad theoretical approaches; the degree with which an individual has agency over their identity formation is a point of some disagreement among some scholars within each of these schools of thought (Block 2013). However, these theoretical categorisations provided a useful- if somewhat arbitrary- means by which professional identity and its formation could be understood when reviewing the studies retrieved by this search. Each of these theories are founded on ideologies that are specifically relevant to the concept of professional identity; these will be discussed further throughout the following sections.

3.3.1.1 Symbolic interactionism

Symbolic interactionism (SI) is a Social psychological theory that describes the production of knowledge and understanding of oneself and the social world in which the individual exists (Burke 2006b). It assumes that the self and the social are distinct entities that are interrelated through conscious efforts (Blumer 1969, Meltzer et al. 1977). SI views an individual as a social actor that is engaged with the world through their interactions with others and the meanings made from those interactions. The studies retrieved from the search- that aligned themselves to this theoretical perspective- identify students as being in a constant state of interaction with other students and educators as they negotiate their transition into the professional domain. Traynor & Buus (2016) discussed how students actively align their own personal values and self-identity to that of the profession. The researchers used a discourse analytical approach to data taken from focus groups of student nurses. Despite this analytical approach being more theoretically consistent with research underpinned by a social constructionist methodology, the analysis found that it was in the interactions between students and professional colleagues that new understandings of professional identity could be generated. The primacy given to interaction and meanings made from observing role models in practice implied a SI stance in the explanation of identity formation. For example, Traynor and Buus (2016) described how student nurses identified potential role models through an understanding of what constitutes ‘good’ and ‘bad’ practice that they shared with each other. These qualitative evaluations of professional nurses’ practice were stated to be based upon knowledge of professional practice that was derived from a number of sources: personal experience, educators, peers, and the public perception of nursing being a ‘caring profession’. This conscious evaluation of observed practice,

and comparisons with the views held by others, indicate that meanings about professional identity are a type of negotiated reality rather than an unconscious or passive internalisation of expected professional norms. A similar approach was utilised by Thomas et al (2015) who claim that students have a stable self-concept whilst trying to 'fit in' to a professional world where they sometimes observe unprofessional behaviours from the nurses in clinical practice. In this study, the authors asked first year student nurses to describe their thoughts on what it is like being a first-year nurse on a first placement. The assumption made by the authors was that the socialisation processes that occur during the earliest stages of the programme were most likely to result in the 'maximisation of a professional identity'. Students reported a conflict between maintaining their identity as a student and experiencing incivility targeted at them from qualified nurses. The authors suggested that students negotiate this conflict by trying to retain their own previously held sense of personal and professional identity whilst 'fitting in' with the professional behaviours of practicing nurses. It is in this interaction between students, their peers and nurses in practice that the students developed a sense of their place in the professional workforce.

The realm of clinical practice and its impact on the emerging professional identity of students was explored by Shakespeare and Webb (2008). This study demonstrated the way in which meaning about the profession of nursing can be derived through the specific interactions between student nurses and their mentors in practice placements. The study describes how the mentor evaluates the student's professional behaviours through a process of meaning-making that was co-created during their discussions of events that had occurred in the student's practice. As with Thomas et

al's study, a pre-existing view of appropriate professional behaviour- held by student and mentor- is evaluated against 'real world' examples of practice. The student subsequently makes conscious decisions about how to adapt their behaviour and their own sense of professional identity to that which is exhibited by the professional nurses that they work with.

Mazhindu et al (2016) described the values and behaviours expected of the nursing profession as being defined by the profession itself. However, students are thought to bring their own ideas about the professional identity of a nurse with them when they join the profession. The study explored how the recruitment strategies are used by the nurse educators to identify suitable applicants to the undergraduate programme. Applicants whose own ideas about nursing's professional identity- that were most closely aligned to those responsible for recruiting student nurses- were considered to be suitable. Following this process, the student then enters into a process whereby the reality of nursing practice has to be reconciled with their own views throughout their education. At the outset of the programme there is some agreement between neophyte nurses and professional ideals, further alignment between student and profession regarding professional identity was suggested to take place through later socialisation processes during the programme.

Students' own personal beliefs and values were a primary mechanism for role modelling in Keeling & Templeman's study (2013). They conclude that students develop much of their professional identity on that which arises from the public's perception of the nursing. The authors describe how students actively seek out role

models that are representative of the public's expectations of nursing, which leads to the formation of a professional identity that is consistent with that view.

The studies adopting a Symbolic Interactionist theoretical framework all described student nurses as having a high degree of individual agency in the process of developing a professional identity (Traynor and Buus 2016, Keeling and Templeman 2013, Mazhindu et al. 2016, Shakespeare and Webb 2008, Thomas et al. 2015). Furthermore, they emphasised that the interaction with peers, mentors and educators was central to the process by which professional identity was formed. Normative inculcation of professional identity as a conscious activity is a process that is common among the symbolic interactionist studies. Active engagement by the student in the professional socialisation process differentiates it from other theoretical perspectives.

3.3.1.2 Social identity theory

Social identity theory takes the view that aligning oneself to a group provides the individual with a sense of purpose and self-worth (Ashforth and Mael 1989, Hogg 2006, Tajfel and Turner 1986). Additionally, belonging to the group affords the individual a feeling of security (Willetts and Clarke 2014a). The study by Clements et al (2016) found that the security of membership to the professional group led to greater commitment and reduced the likelihood of attrition. However, the study also highlights alternative cases whereby the students can feel like outsiders in clinical practice, as a result of their professional identity being constrained by their status as a student. Whilst the study highlights the positive relationship that exists between professional identity and work-role, the study also reveals the impact of social identity and group membership on the student's self-identity. It is suggested that the dual identity of being a student and being a nurse can challenge the student's commitment and sense of belonging to the profession. Only one study adopted this theoretical framework. Symbolic interactionist theory appears to be the most commonly used approach in the research of professional identity in nursing. Symbolic Interactionist research is primarily focused on a process of interaction rather than individual motivations of self-worth and belonging. However, a relationship between individual motivation, self-worth and group belonging might be implicit within the socialisation processes.

3.3.1.3 Social constructionism

The social constructionist view of professional identity formation suggest that the values and behaviours of the nursing profession are defined by broader social influences. There are a broad range of perspectives on how Social Constructionist research seeks insight into the social world and how it shapes the behaviours of those within it (Cerulo 1997). The studies using this theoretical perspective (Baldwin et al. 2017, Christiansen 2011, Kelly et al. 2017) all take the position that the terms of reference of professional identity are defined from outside of the profession. They contend that the students entering the profession have low levels of individual agency in how they will develop their professional identity. Kelly et al (2017) described how professional identity can be reinforced by developing a deeper knowledge of nursing's past. The history of nursing influences the way in which the public view nurses, and Kelly et al argue that students can be shaped by engaging with this knowledge of nursing's past. They conclude that the role of the educator is to act as a facilitator in the shaping of student nurse behaviour and to help students to develop a strong professional identity. This implies that the origin of this normative template of the 'good nurse' is a product of the education process rather than from wider social influence; which is somewhat contrary to the theoretical stance of social constructionism. Nurse educators are therefore positioned as the point of origin of nursing's professional identity, rather than as intermediaries in the construction of professional identity.

Patient's narratives have been implicated in the development of student's professional identity. In one study, student's reflected on stories that were posted

onto a website by patients following an episode of nursing care (Christiansen 2011).

The author suggested that, by viewing the nursing profession from a user's (or outsider's) perspective, that students could gain a sense of how the profession is perceived, and the expectations that patients had about nursing. This suggests a primacy of establishing a sense of professional identity from a broad social origin, and not from within the profession. However, the purposive selection of patient narratives for this process was made by nurse educators. This suggests an assumption that there is a consensus between the nurse educators and the public view on the nature of professional nursing. Nurse educators exposed students to certain patient narratives that were selected because they correspond to a broader narrative of the nursing profession.

3.3.2 How is professional identity defined in nursing literature?

Absent from the literature reviewed was a definitive statement about what professional identity is. Whilst the term was used quite freely throughout the background and discussion sections of the studies, there appeared to be certain assumptions (or possibly an inability to objectively define) the precise nature of professional identity. Definitions of professionalism and nurse's professional role were often cited in lieu of this. Moreover, the term professionalism and professional identity were commonly used synonymously. Being a professional and acting in accordance with professional norms are closely related but could also be considered to be conceptually distinct. Without this distinction, professionalism might be reduced to merely conforming to a set of expected behaviours; behaviours that are arbitrarily disconnected from an individual's motivations, goals, values and self-concept. This leads to ontological question about the relationship between 'being' and 'doing': Do the actions of nurses define them as nurses? Or might those actions belie their true sense of self, their motivations and their intentions?

Values and ideals are frequently cited as central to the nursing profession (Arthur et al. 1999, Duquette 2004). The nursing profession's popular identity as a 'caring profession' demonstrates the primacy that is afforded to the personal attributes and of its members (Benner and Wrubel 1989, Spichiger et al. 2005). The studies reviewed followed this same notion: nursing's professional identity is primarily associated with its affective attributes (personal values), with physical attributes (tasks) being somewhat secondary in importance.

During the analysis of the literature, it was clear that some implicit assumptions were made that shed light on the way in which the authors perceived professional identity in nursing. These assumptions emerged as four themes that define professional identity as: A work-role; Being part of a professional group; A public image, or; A set of values and behaviours. Each of these defining themes around professional identity brought their own specific insights into the transition of a lay person to that of a professional; each had their own nuance with regards to the process by which this occurs. However, all studies shared the aim of exploring how students move from being a lay person towards the goal of achieving a professional identity, despite there being no objective outcome measure stated, and no specific definition to act as a reference point to evaluate the success of these processes.

3.3.2.1 Professional identity as a work-role

The nature of the work undertaken by nurses and the specific objectives of that work were viewed by some authors as being that which gives shape to the nurse's professional identity. The link between being a professional and having a specific work role was evident in this literature; nursing being viewed as a primarily practice orientated profession and being defined by the observable actions of the nurse, is perhaps unsurprising. However, in terms of the student nurses' identity, this raises a point of conflict; students were described by Clements et al. (2016) as having a dual identity because of their status as both a university student and as a working nurse during clinical placements. In this study, students described the importance of 'commitment' to the work required to become a nurse. This work is both academic and practical (taking place in the university and in clinical placements or skills-based teaching sessions). Some of the students studied defined their identity as being more aligned to one than the other; for example, being more competent at skills than the academic work. This separation between being a student and being a nurse, exemplifies the author's definition of identity being related to the work-role that was currently assigned to the student at any given time. Therefore, being committed to the work role (be that as a student, or as a nurse) is given as an essential element of developing a strong professional identity. Taking an alternate view of student's dual identity, Kelly et al (2017) consider that the students' divided affiliation between university and healthcare institution might lead to the students' professional identity being stymied. In this study, the authors analysed the reflective diaries of students who had visited the Florence Nightingale Museum in London. This analysis identified the impact that an understanding of nursing's past had in helping the student to establish a bond between university work and clinical placement. Such a

bond, it is proposed, might strengthen the students sense of professional identity. So, in addition to identity being associated with work role, there is also the suggestion that identity might be constructed from nurses work that is no longer found in contemporary practice.

There is another dimension that sees the work-role as not only ‘what we do’ but also to what students *perceive* is being done in by professional role models. In this respect, professional identity is more than just an arbitrary occupational definition, it alludes to a less visible form of professionalism in practice. This is exemplified by an analysis by Baldwin et al. (2017) in a study of how nurse educators possess a dual identity as both a nurse and as an educator, and the impact that this has on the development of professional identity in their students. In this study, the nurse educator’s negotiation of the role of educator (which carries its own professional identity) and that of being a professional nurse is described as conflicting. The authors conclude that a balance needs to be found between retaining the nursing identity with the identity of becoming an academic so that expected professional behaviours can be modelled to the students. The nurse educator must exemplify professional behaviours and values associated with academia whilst simultaneously maintaining professional credibility in the eyes of their students. As a result, the students must also reconcile their perceptions of the educator’s identity as a teacher but also as a professional nurse.

These studies show that professional identity as a product of a work-role is not as straightforward as simply fulfilling occupational obligations, it is also about how

membership of an occupational group is perceived in the eyes of others. There is clearly a dialectical relationship between self-concept and social constructions of professional groups and their identity as evidenced in these studies.

3.3.2.2 Professional identity as being a part of a professional group

Affiliation with a professional group appears to be a central component of professional identity in the studies reviewed. Membership of the group is suggested to bring a range of positive benefits to the students: a sense of belonging (Kelly et al. 2017); a coherent set of values, beliefs and attitudes (Mazhindu et al. 2016); a sense of commitment (Shakespeare and Webb 2008), and embracing a 'way of life' (Keeling and Templeman 2013). The benefits of being part of a professional group transcend the diverse contexts in which nursing takes place. The literature describes studies that were undertaken with students from Adult, Child health, Mental health and learning disabilities branches of nurse education. Despite the very different roles associated with these fields of practice, there is an overarching view that professional identity in nursing is associated with being part of a large professional group that is broad in its aims and is bound to a long and well-established history. Kelly et al. (2017) analysed student reflections on nursing's history and discovered that factors such as uniform design, participation in nursing organisations and exposure to interprofessional learning can all have a significant impact on professional identity development. Keeling and Templeman (2013) go further to describe how the individual's identity as a nurse might have a positive impact on the student's feelings of self-worth outside of the profession; influencing their social being and bringing with it a sense of moral obligation to the wider community in daily life.

This literature review highlights how professional identity in nursing is an alignment of the individual's personal values, beliefs and moral orientation to those that are perceived to be associated with the nursing profession. Furthermore, this alignment

is claimed to provide a feeling of belonging; that the individual has a continuity with the wider professional body and a shared history. This continuity emphasises a positive relationship between self-concept and professional group membership.

3.3.2.3 Professional identity as a public image

Mazhindu et al. (2016) suggests that the expectations of nursing are laid out by global healthcare demands and that these expectations construct a view of the profession that informs the identity of its members. From this perspective, the profession itself is shaped in response to changing healthcare needs rather than by mandate of the profession. The expected behaviours and values of the profession are therefore imposed on nurses by external imperatives. However, this implies again that the identity of the profession and the work-role of its members are one and the same; that identity is a visible set of behaviours that must be adopted by nurses in response to social influence. Public expectations of the nurse being intelligent, capable of effective decision-making, innovative and able to deliver safe care, were described by Christiansen (2011) and Mazhindu et al. (2016) . These images of the nurse as a ‘modern professional’ might have originated from external public expectations but are also reproduced through: regulatory guidelines (such as the NMC Code); expectations from healthcare institutions; and from student nurse recruitment criteria. Opposed to this image were those that have been retained from historical views of nursing and were still used to define contemporary professional practice (Kelly et al. 2017, Keeling and Templeman 2013). The long history of the nursing profession seems to have a profound influence on contemporary practice. Some authors cite this as an inhibitory factor in the acquisition of a professional identity (Mazhindu et al. 2016, Keeling and Templeman 2013), whereas Kelly et al. (2017) view it as an opportunity to re-establish the profession’s identity in an ever changing healthcare landscape.

3.3.2.4 Professional identity as a set of values and behaviours

Whilst no specific defining statement about nursing's professional identity was found in these studies, each study took a position on how we might understand it. Clements et al (2016) report how students described how their commitment to the development of a professional identity is crucial to becoming a professional nurse. Student nurses cited the importance of learning professional values such as compassion and non-discriminatory practice. Traynor and Buus (2016) described how students identified caring as an innate characteristic for nursing's identity and that this became a reference against which students evaluated the behaviours of the nurses encountered in their clinical practice placements. There was also a perception that the profession should be comprised of 'the right people' who could be identified by evaluating applicants' insights into nursing during the recruitment process (Mazhindu et al. 2016).

Thomas et al (2015) found that students in the first year of the nursing programme placed high value on the importance of acquiring personal values and attitudes during the early socialisation process of nursing education, believing that this leads to a positive professional identity in the future. Accordingly, Keeling and Templeman (2013) found that final year student nurses also defined their practice in terms of values rather than skills and alluded to the need for behaviours such as autonomy, self-regulation, belief in public service and a sense of vocation. Professional identity was therefore revealed by these students to be distinct from the skills and tasks associated with nursing practice; a view that appears to be unchanged between the first and final years of nurse education.

3.3.3 Processes described in professional identity formation

The transition from lay person to professional nurse was the subject of all studies reviewed. Despite the variety of contexts and research aims, the studies were all concerned with how students develop professional identity. Despite a lack of clarity and consistency about how professional identity in nursing can be defined, all studies assumed that students were engaged in a process orientated towards this goal. The term socialisation was commonly used to describe the process of acquiring a professional identity. The route taken to this end, and the factors that influenced the process, varied. Role modelling was described as being an essential component of the socialisation process and central to the way in which professional identity formation was assumed to occur. Whilst these two concepts are not mutually exclusive, their role in describing the formation of professional identity can be explored separately.

3.3.3.1 Role modelling

A process whereby incoming students to the nursing profession had their preconceptions deconstructed and reconstructed during their nurse education is described by Shakespeare and Webb (2008). In this study, the authors describe how students learned to model certain behavioural norms- associated with the profession- through the analysis of their reflective discussions with mentors in practice. Professional behaviours were said to be internalised when the students' previously observed experiences were brought to the students' attention by the mentors. The discussion between the mentors and students concerning the positive and negative aspects of these experiences formed a reference point from which the student could then model their future behaviour. In this case, socialisation is defined as a means of conforming to a set of behaviours that have been set out as those that are consistent with professional practice. The degree of agency that students possessed when being socialised into the professional group is not fully explored in these studies. It is possible that the student is not entirely passive in the process because they are able to make decisions about how to react to episodes of practice that conflict with their perception of professional norms. However, the extent to which they have control over how they manage this situation and develop their own future is not made clear.

Nurse educators are cited as being important role models in the socialisation process both in the classroom and in clinical practice. Baldwin et al (2017) explored how nurse educators demonstrate positive professional behaviours for students. The authors concluded that this role modelling is not limited to the classroom but can occur in every interaction nurse educators have with their students. Students were

able to recognise behaviours and attitudes that were exhibited by educators that were consistent with those that they saw in clinical practice placements, and those that were not. The nurse education programme is therefore assumed to provide a key formative period for developing nursing identity, as this is a time when students will gain the knowledge and skills that separate professional nurses from lay people (Kelly et al. 2017). Furthermore, Kelly et al's study found that the educators could enable the students to establish a link between the past and present realities of nursing practice. These links were suggested to provide a sense of nursing's historical function that is evident in contemporary nursing.

The values that students bring to the profession and their perceptions of the professional nurse identity are claimed to undergo transformation during the nurse education programme. Role modelling was described as the key process by which student nurses strengthened their existing sense of professionalism (Keeling and Templeman 2013). It was suggested that students required a clear idea about nursing's professional identity prior to commencing nurse education. Existing ideas about nursing were reinforced, or transformed, as a result of being exposed to both positive and negative examples of professional practice during the programme. This implies that role modelling is not simply a case of imitating the behaviours of professional nurses but requires the student to actively reflect upon their own perception of professionalism and to adapt it to the professional norms observed in practice. This view of role modelling, as an active and adaptive process, was also evident in the study by Traynor and Buus (2016). Students recognised the potential for some nurses to be good role models when they demonstrated values and behaviours that were closely aligned to the student's own description of

professionalism. In both studies, the criteria used by students to discern good and bad examples of professional practice, and to identify positive role models, are claimed to be based upon the students own set of personal values and their own pre-existing perception of what constitutes positive professional practice. However, no attempt to explain the origin of these perceptions is offered in the literature reviewed.

3.3.3.2 Socialisation

Role modelling and socialisation are discrete concepts but share common features; the former has been stated to be a function of the latter (Thomas et al. 2015). Clements et al (2016) highlight clinical practice placements as being crucial to the professional socialisation of nursing students in the same way it has been implicated in role modelling. Professional identity is observed first-hand by role models and then, through the process of socialisation, that identity is inculcated into the student's behavioural repertoire. Socialisation involves explicit teaching and informal learning (Traynor and Buus 2016) but it does not necessarily preclude other passive or subconscious processes that are not described in these studies. The student is immersed in the world of clinical practice in which they are exposed to a wide range of attitudes and behaviours (Thomas et al. 2015). Some nursing practices observed will normatively orientate the student towards the profession's identity (Kelly et al. 2017). Others that act as points of conflict, require the student to internalise an established set of guiding principles. These principles originate from regulatory documents, such as the NMC code (NMC 2015), or from negative cases, such as external critiques of nursing that appear in the media. Students can therefore recognise practice that should, or should not, be adopted and are subtly socialised into the establishment of a consistent professional identity (Christiansen 2011, Traynor and Buus 2016).

The extent to which the student is an active participant in the socialisation process is reported in different ways in these studies. The theoretical assumptions made by the researchers influence the claims about the agency that the students possess

throughout the professional socialisation process. For example, those studies that explore socialisation from the perspective of Symbolic Interactionism (Traynor and Buus 2016, Thomas et al. 2015, Mazhindu et al. 2016, Shakespeare and Webb 2008), suggest a higher degree of agency by the students than those that are grounded in the Social Constructionist perspective (Kelly et al. 2017, Baldwin et al. 2017, Christiansen 2011). The study by Clements et al (2016) that examines socialisation from the theoretical standpoint of Social Identity theory, is less fixed in its position. In that study, it is claimed that students are required to be actively engaged and committed to the profession. However, this shares some common ground with the Social constructionist studies, inasmuch as it implies that the student is passively engaged in the internalisation of predefined professional behaviours; with those students who do not demonstrate the same commitment to the profession's values being viewed by other students as potentially unsuitable for nursing (Clements et al. 2016).

In the literature reviewed, socialisation is intrinsically bound to the development of professional identity; they are discussed synonymously. However, the literature reveals that there is some uncertainty about whether the student is actively or passively engaged in the socialisation process, and about the degree of agency that students possess in negotiating conflict and internalising professional behaviours. Socialisation is an essential process in the formation of professional identity. Formation of professional identity is not a synonym for socialisation. Socialisation is the process, formation of professional identity is the outcome of that process.

3.4 Discussion of the literature

The studies reported here are only those that have been published in the UK in the past 9 years and represent a specific and focused view of the scholarly publications in the field. However, there is also a considerable interest in professional socialisation and professional identity formation in the international literature that was not included due to reasons of relevance to the purpose of this review (as outlined in section 3.2.3). Nevertheless, the UK studies reviewed demonstrate a wide range of theoretical perspectives about the ways that student nurses develop their professional identity. The three theories that frame these perspectives highlight some inconsistency and lack of agreement about professional identity and its acquisition.

3.4.1 Defining professional identity

The lack of a definitive statement about the meaning of professional identity is evident from the literature. The characteristics of professional identity in nursing appears to be contingent on who is defining it. The public and the profession might offer different views of what it means to be a professional nurse and base these views upon differing expectations about the role of nursing in contemporary healthcare provision. The various ways in which these studies talk about nursing's professional identity reveal a lack of clarity as well as an inconsistent approach to our understanding of its development. There are four principle categories in which the literature describes professional identity. It is described as:

- 1) A product of public image.

- 2) The work-role that is associated with the profession.
- 3) A set of values and beliefs about the nature of nurses themselves.
- 4) The membership of an occupational group.

Each of these domains will be placed into the wider body of literature that spans many decades. Relevant literature will be discussed in the following sections to illustrate how these differing views about professional identity fit into our current understanding.

3.4.1.1 Public image

The nursing profession appears to be bound to its history, and this history provides a reference point for the public view on the image of nursing. As highlighted in chapter 2, changes to the structure of nurse education have raised questions in the public domain about how contemporary nursing practice might be at odds with a wider perception of the traditional role of the nurse. Kelly et al's study emphasised the importance of student nurses actively engaging with this nursing history so that their identity is developed through an understanding of the past role of nurses as healthcare providers (Kelly et al. 2017). However, Ten Hoeve et al (2014), in their review of 18 studies published between 1997 and 2010, exploring the public image of nursing, concluded that the public image of nursing is: diverse, incongruous, largely invisible and lacking in a professional identity. This perception, they state, is a result of nurses failing to engage in a public discourse about their contemporary professional contribution to healthcare. Whilst an 'outsider' view of nursing might not concur with that held by nurses themselves, it has been identified as having a

profound influence on the way in which nurses see themselves as professionals (Takase et al. 2002) .

Berger and Luckman, in their treatise on the social construction of the social world, claim that institutions (such as the nursing profession) are not created instantaneously but are products of their historicity, and that it is impossible to understand an institution adequately without first understanding the historical process by which it has been produced (Berger and Luckmann 1967). Nursing cannot therefore be separated from its history, but consideration must be given to the positive and negative influence that history might have on the profession's identity. The extent to which nursing keeps sight of its past might have a significant impact on the way that the public view the profession and the way in which nurses currently perceive their professional status.

The nursing profession being a largely female workforce, has resulted in a perception held by some nursing scholars that it is likely to be subjected to the patriarchal constraints of a feminine vocation (Hallam 2000, Capparelli 2005). However, in some specific fields of nursing (notably mental health nursing) the workforce is less well defined by these gender characteristics (McCrae et al. 2014). The vocational image of nursing held by some commentators outside of nursing has provided challenges, that must be overcome by nurses, in their efforts to be perceived as a profession (Crawford et al. 2008). Crawford's study reveals the means by which Community Mental Health Nurses reconcile their own professional identity in the face of the critics, from those outside of the profession, who retain a

view that nursing is a low status profession in comparison to other professional groups. Nurses strive for recognition and legitimacy in their caring role but often find that this contribution to healthcare is ‘invisible’ to others (Maben 2008, Huynh et al. 2008).

The transition from vocation to professional status has been influenced by complex factors, including university education, developing a distinct body of knowledge, and gender (Yam 2004). The nursing profession has been required to overcome these factors in order to receive acknowledgement for its contribution to patient care (Allen 2004). The impact that the public image of nursing has on nurses themselves and the way in which they describe their contribution reveals a complex formative process for professional identity. Detailed exploration of the interrelationship between self-concept, professional identity and the impact of public image is still lacking in the published literature and deserves further attention if the processes contributing to professional identity formation are to be better understood.

3.4.1.2 Work-role

Relating professional identity to the occupational role that an individual performs, emphasises the importance of exhibiting ‘visible’ behaviours that are associated with that role. Observable behaviours might be the only tangible means by which a person, from outside of a profession, can recognise the contribution that the professional makes to society, and to the quality of their work (van Mook et al. 2009). Crawford et al (2008) consider the way that nurses define themselves by their work, they build upon other research that describes ‘identity-work’ as being pivotal

to a nurse's understanding about their professional role (Cook et al. 2003, Fagermoen 1997, Hood et al. 2014). They describe how the observable behaviours of nurses define who they are as professionals. This is stated to be a means by which the nurse can present themselves as visibly attending to their role and justifying their work as admirable and necessary (Paley 2002). However, the authors highlighted that a conflict exists between a public perception of the profession and the 'reality' of nursing practice as students see it (Childs and Stoeber 2012). As nurses struggle to find legitimacy in their work, the public image of nursing remains contested in the context of a pervasive public image, in which nurses are still perceived as being subjects of a popular ideology about 'tea and sympathy' (Crawford et al. 2008).

3.4.1.3 Membership of an occupational group

Professional identity, as viewed by social identity theorists, arises from a reciprocal relationship between the individual and the profession; with members each deriving a sense of unity from one another (Tajfel and Turner 1986, Tajfel 1974).

Commitment to the nursing profession has been associated with an increased sense of professional identity among student nurses (Clements et al. 2016). The nurse's commitment to the profession has been linked to enhanced practice, safety and quality in nurse's work (Teng et al. 2009), job satisfaction, and the development of a set of positive professional values (Jafaragae et al. 2012). A strong sense of commitment to the profession might arise from shared values that originate from the notion of 'vocation' in the provision of patient care (McCabe and Garavan 2008). However, working practices that fit with the personal life of the individual (such as flexible shift patterns) have also been implicated enhancing commitment to the

profession (Brooks and Swailes 2002), implying a practical explanation for commitment rather than an emotional attachment to the profession. No conclusive agreement is found in the literature regarding the direction of causality between commitment and professional identity; whether a positive professional identity enhances commitment or whether commitment reinforces professional identity.

Social identity theory has been proposed as a valuable research framework to clarify and describe the professional identity of nurses, as it emphasises the importance of belongingness as a consequence of the interpersonal-intergroup continuum (Willetts and Clarke 2014a). This focus on the individual and their relationship to the group places the individual in the centre; being focused on the individual psychological perspective of group membership. Whilst an interrelationship between the individual and the group is said to exist, the primary processes described in social identity theory are centred upon how a person develops an identity as a result of being a part of that group. If professional identity is produced by positive feelings derived from being part of an occupational group, it might be concluded that professional identity can be defined as a feeling of being and belonging, rather than the positive feelings associated with the performance of the nursing role. Understanding the motivations of student and registered nurses to enter and to remain in nursing is key to understanding the role of commitment to the profession in the formation of professional identity.

3.4.1.4 Values and beliefs

Defining professional identity as the possession of the values and attributes associated with being a part of a professional group, lies at an intersection between self-concept and occupational group membership. The literature highlights the importance of personal attributes of nurses (or the individual entering nursing) being aligned with those that are stated to be a prerequisite for attaining the status of a professional nurse. The individual derives a sense of belonging to a group that share similar values and attributes, and the profession thus becomes comprised of members who are agents of its own set of predefined values (Tajfel and Turner 1986).

The origin of the values and attributes associated with nursing can be identified in the regulatory guidelines and constitutional statements that guide nursing practice. The NMC Code and ESC's outlines core values, beliefs that nurses must exemplify in their practice (NMC 2015, NMC 2010). These values are underpinned by the ethical and moral orientation towards the protection of, and service to, society. A broader set of values are laid out in the NHS Constitution; a statement that sets out the objectives of the organisation and the principles that provide the foundation of its mission (DoH 2015). The NHS constitution describes an overarching set of values that the public should expect from healthcare providers. These values include respect, dignity, patient involvement and freedom to make informed choices; values that are also central to those of the NMC Code. Hence, there is a unifying set of values that are consistently reproduced by the nurse, the profession and the organisation.

The requirement for nurses to be caring and compassionate is widely stated both inside and outside of the profession. In a policy document by the Chief Nurse of Great Britain, the values that should underpin nursing practice were laid out (Cummings 2012). These values were clustered around the '6 C's' of Care, Compassion, Commitment, Courage, Communication and Competence. Whilst these values are not unique to the nursing profession and are, in themselves, broad concepts, they espouse a specific identity for the nursing profession. These six concepts are held up as the profession's defining values and beliefs despite their ubiquity.

The concept of caring- as the ontological and epistemological foundation of nursing- has a long history (Watson 1979, Leininger 1978). However, the literature of caring in nursing is vast and, at times, contradictory (Morse. J 1991, Smith 1990, Paley 2002, 1996, Lewis 2003). Defining professional identity as being a set of values that are not unique to the discipline, and potentially lack precise definition due to their inherent subjectivity, might be problematic. Nursing cannot easily be distinguished from that of other healthcare providers if these values are the sole means by which the profession is identified. Therefore, their contribution to professional identity must be contingent upon other more specific defining concepts (Sargent 2012). If the origin of the values and beliefs of the profession originate from outside of the profession, then it might be assumed that there is a dominant discourse from which the profession's identity is constructed. If this discourse is then reproduced via organisational and professional mandate (for example NHS Constitution and NMC Code), then the profession of nursing is a construction of the social world rather than a self-determining professional group. However, some nurses find that this dominant

discourse of nursing does not fit easily with their own perceptions of practice and leads to an unstable identity (Crawford et al. 2008) and role-conflict (McCrae et al. 2014). Therefore, there appears to be an interrelationship between how nurses define themselves as a professional workforce, and the values that provide a moral and ethical orientation for their work. Retaining these values throughout a nurse's career can present a challenge when nurses are faced with practices that they see as conflicting with these values. Such conflict might lead to adaptation of beliefs to that which are observed or, if unmanaged, can lead to stress and dissatisfaction with the profession (Maben et al. 2007). The origin of the values and beliefs that the nursing profession is founded upon is unclear. Clarity is needed about whether these values: are terms of reference that nurses themselves have designated to their work; whether nurses are a professional group comprised of individuals who are drawn together by a shared commitment to the same values; or whether the profession has (and continues to) be shaped by a broader narrative and social influence.

3.4.2 Professional identity formation

The socialisation of student nurses has been described to be a process of shaping or moulding the student towards a pre-defined set of values (McCrae et al. 2014, Feng 2012, Howkins and Ewens 1998, Rejon and Watts 2015) or the development of appropriate professional behaviours (de Swardt et al. 2017, Houghton 2014).

Professional behaviours are handed down to new nurses so that they can perform the expected role. The Professional behaviours acquired can be visible or invisible.

Visible behaviours are associated with tasks and practice skills (Scully 2011).

Invisible (or less visible) behaviours include the delivery of care that is caring and compassionate (Maben 2008, Maben et al. 2007), and critical decision-making skills (Severinsson and Sand 2010).

Students are socialised into the nursing profession during the nurse education programme through their interactions with faculty members and through the experiences gained by practicing nursing (Day 2005). This process of internalising the espoused values of the profession, taking on the observable behaviours and developing skill in the less visible functions of the nurse, all contribute to successful socialisation (Mackintosh 2005). Socialisation is characterised by four attributes: learning, interaction, development and adaptation and role-modelling might encompass each of these characteristics (Rejon and Watts 2015). Role modelling is widely discussed in the nursing literature as an essential process by which professional identity is formed (Baldwin et al. 2017, Charters 2000). However, the effectiveness of role-modelling can be dependent on the student's incentive and

motivation to learn (Bandura 1977), and the ability to recognise appropriate role-models for learning (Vinales 2015).

In the UK, all nursing students are assigned a mentor in their clinical placements. The mentor is expected to facilitate the students learning by exposing them to suitable learning opportunities and to model appropriate professional behaviours (NMC 2008) and act as a role-model (Eller et al. 2014). Neophyte nurses are reliant on the mentor to model professional behaviours due to their own lack of exposure professional practice. However, nursing students, in the early stages of the socialisation process, are still able to recognise the values exhibited by mentors as conflicting with their own (Traynor and Buus 2016, Thomas et al. 2015, Hoel et al. 2007). These value judgements indicate that a pre-existing schema of nursing behaviour is brought, by the student, into the profession. On what factors these judgements are made, or the criteria used to evaluate expected practice, is not clear. Nevertheless, these prejudgements indicate that a wider discourse about the identity of the nursing profession is influencing nursing students before, and during, the socialisation process. One example of how this discourse constructs the professional identity of nurses is seen in the public's perception of the nursing profession as a low status profession (Randle 2001, Sims 2011). The student nurse's experience when working in an increasingly technological and autonomous role does not fit well with the perception that a nurse's role requires lower education standards in comparison to other professions and is symbolised by passivity, and vocation (Childs and Stoeber 2012). The outsider's impression of nursing having a low status in comparison to other professions has also been implicated as a negative influence on

the formation of professional identity (Kroger and Marcia 2011, Waterman 1999, Bradbury 1990).

A sense of belonging to the profession might enhance professional socialisation (Zarshenas et al. 2014) or, conversely, socialisation might reinforce a sense of belonging to the profession (Clements et al. 2016). The inter-relationship between the student nurse and the nursing profession, and the role that professional socialisation has on the formation of a professional identity is somewhat unclear from the literature. The theoretical foundations of each study of professional identity results in different conclusions about the aspects of professional socialisation that have the greatest impact on the formation of professional identity. Central to this lack of clarity is the question about the degree of agency that the student nurse has when undergoing a period of professional socialisation. Whether the student is passive and is shaped (or unconsciously transformed) by the process, or whether the student actively engages (and negotiates terms of reference) throughout, requires further understanding.

3.5 Summary

The literature reveals that professional identity, in its broadest sense, is the confluence of meanings that are associated with being a nurse. These meanings arise from both the profession itself and from the wider social world. In this respect, professional identity is subjective and contingent. Despite attempts to understand some of the factors that contribute to professional identity and its formation, the concept itself remains elusive and poorly defined. However, the literature has shown how the sense of identity that nurses develop is constructed from: public perceptions and expectations; consensus among nurses about the role definition and its associated value base, and from the self-concept that is influenced by being a part of an occupational group. These origins of professional identity align themselves with the theoretical perspectives of Social Constructionism, Symbolic Interactionism and Social Identity Theory respectively. Whilst these theories are distinct in their assumptions and their methods, they do share some ontological common ground that is centred on the way that language can be used to define meaning and to reproduce knowledge that informs nursing's professional identity. Exploration of the discursive relationship between the individual and the social world has allowed the authors of these studies to make claims about factors that influence the development of professional identity among nurses. All the studies reviewed explicitly or implicitly have taken a theoretical position on the nature of professional identity. All have revealed in some way that professional identity is produced and reproduced by the social world; a world of which the nurses themselves are a part and in constant interaction with. Hence, if we adopt the notion that professions are a product of- and constructed by- discourse, then we find ourselves trying to unravel a complex

network of interrelated discursive relationships between nurses, patients, healthcare institutions and education providers. Within these relationships there appear to be many potential factors that influence the process by which an individual becomes a professional nurse and the resulting professional identity that is acquired from that process. We are therefore left with two unanswered questions: Who defines the terms of reference for professional identity in nursing? And by what processes do students nurses develop their sense of professional identity?

4 Research Method

This chapter outlines the research design, the method chosen for the study and how it has been used to guide the data collection, data analysis and the development of the resulting conclusions. A brief background to the chosen research method will be given, followed by a detailed description of the design of the study which consisted of focus groups and individual interviews. The chapter will conclude with a discussion of how rigour was maintained in the research design and the resulting findings.

4.1 Aims and objectives

In the previous chapter, it was concluded that the identity of an individual is comprised of personal experience and culturally derived meanings which are made from those experiences. The symbolism of these meanings creates a lens through which each individual comes to know their personal and professional world. As such, each person who chooses to enter a social group- such as the nursing profession - will do so with a set of understandings about what it means to be a member of that group. Furthermore, each individual who makes this transition has their own motivations and goals.

The aim of this study is to understand the process of becoming a professional nurse in detail by exploring the experiences of those making the journey into the professional nursing world. Moreover, it seeks to understand how this process might be influenced by broader social factors before and during the period of professional

socialisation. To meet this aim and to focus the research design, the research question is:

How do preregistration undergraduate student nurses construct their sense of professional identity?

The following objectives will be used to provide further focus and structure to the data collection and analysis:

- Gain an understanding of how students perceive the role of the nurse at the beginning and throughout the pre-registration programme.
- Identify any changes to student's sense of professional identity as they progress through the programme.
- Explore student's narratives about the formative experiences, and the individual and social factors that influence the process of becoming a professional nurse.
- To provide an explanation of the process of professional identity formation amongst pre-registration student nurses.

4.2 Methodological justification for the study

The method of investigation that is chosen for a study is dependent upon the assumptions that the researcher makes about society; with each assumption (or branch of scientific enquiry) being based upon a specific set of theoretical perspectives (Bowling 2009). In choosing the most suitable research design, two questions about the study were initially considered:

- 1) What is already known about this subject?
- 2) What does this study attempt to discover?

The first question was intended to highlight where this study fits within the existing literature about the subject. In answering this question, it can then be established whether the aim of the study is to test existing theoretical perspectives on identity, or whether the generation of a new explanatory theory is needed. The previous chapter has shown how much of the existing literature about identity formation has arisen primarily from studies that assume that individuals consciously adapt their own behaviour in response to external stimuli. These studies explicitly or implicitly make the individual the primary agent of this adaptation. Whilst this literature can offer useful explanations about identity formation, there is clearly a paucity of literature that positions the individual as a subject of the social world in which they exist. This assumption- that social influence might have an influence on the individual's ability to exercise this agency- appears to have received little attention in the existing literature about identity formation. In terms of the second question (what the study attempts to discover), it is then partially answered (the study being intended to address this gap in our current understanding) but, in addition to this, the method by

which this discovery needs to take place has to be made explicit. As this study does not intend to test an existing theoretical explanation or hypothesis, the study is required to generate some new explanations of the phenomenon. The area of interest is concerned with how the social world might shape the behaviours and values of individuals who enter a profession. The view that the individual's reality is co-created between the individual and their social world is consistent with the social constructionist position. This study utilises the social constructionist world-view to discover how a professional identity is constructed through the exploration of the social influences as well as those of personal motivations and values. The overall aim is to cast new light on the process in a way that had hitherto not been fully addressed in the existing literature.

The meanings that students make from their experiences (that are derived from their professional and social worlds) form the data from which this study generates an explanation of the process of developing professional identity. The inherent subjectivity in these accounts requires that the research approach should preserve the nuances of the participants' experiences and perceptions, so that a rich description of the phenomenon is developed. Therefore, the study is designed to capture and analyse the individual student's explanations of the phenomenon by utilising a qualitative research design. This exploration of the process, by which professional identity is socially constructed, requires that the research design adopts an open and inductive approach, whereby the data has primacy, and that any emerging theoretical framework is derived from that data (Holloway and Wheeler 2010).

This study is focused on the interplay between the individual's notion of self, and in the broader social perspectives about what it means to be a professional nurse. To begin an in-depth exploration of this complex process it is necessary to gather rich data about the motivations, experiences, perceptions and goals of those who choose to become professional nurses. As a result, an inductive approach provides the best fit to these aims and objectives. Moreover, a systematic method of gathering and analysing data from which a theory can be inductively 'discovered', supports the decision to adopt the grounded theory method.

4.2.1 Constructivist grounded theory methodology – an overview

Grounded theory is a method of conducting qualitative research that develops inductive theoretical analyses of the data collected (Charmaz and Bryant 2011). The grounded theory method was first described by Glaser and Strauss in 1967 as an approach to the exploration of phenomena that contrasted with the more positivist research methods of the time. The historical development of Grounded Theory Method (GTM) arose from the tension between qualitative and quantitative sociology research in the United States during the early 1960's. At that time, the methods for data collection and analysis of social phenomena were relatively unstructured and poorly documented (Charmaz 2014: p5). Following the publication of their book *The Discovery of Grounded Theory: Strategies for Qualitative Research* (Glaser and Strauss 1967), data collected from qualitative studies were given explicit analytic treatment and produced theoretical analyses that were 'grounded' in the data from which they had been derived (Charmaz and Thornberg 2011). Over the following decades, a divergence became evident between the approaches of Glaser and Strauss; each rendering different descriptions of the method and their theoretical assumptions (Charmaz 2014, Kelle 2005). Glaser's view was that GTM is a method of discovery that treats categories as 'emergent' from the data, which emphasises the analysis of basic social processes. Strauss, however, saw the method as one of theory verification. This divergence has been described as a conflict of *Emerging vs. Forcing*; that theory is either derived inductively from the data, or that existing theory is verified in the analysis, implying a more deductive approach (Kelle 2005). However, the methods proposed by both Strauss and Glaser (in their writing together and individually) were still considered by some to be

subscribing to an outdated modernist epistemology by relying on the authoritative voice of the researcher, fragmenting the respondent's story and blurring the differences in the respondents' accounts (Charmaz 2014). During the 1990s, new perspectives on how GTM could be applied in a postmodern world gained momentum. The role of the researcher as a passive observer and the participant as a reporter of an objective, external reality was called into question. Instead, the notion that social reality is multi-faceted and is constructed through social practices was incorporated into GTM in the Constructivist Grounded Theory Method (CGTM) (Charmaz 2006, 2011, 2014). This constructivist approach to GTM rejects the notion that the researcher is a neutral observer and value-free expert and that the researcher's position, privileges, perspectives and interactions need to be taken into account (Charmaz and Bryant 2011). Furthermore, Charmaz argues that viewing research as a process of construction rather than discovery encourages researchers to be reflexive about their actions and decisions during the research process (Charmaz 2014). The resulting theory is not intended to describe professional identity through abstract conceptualisations about an external reality but instead, to provide an in-depth analysis of a co-constructed professional world of which both researcher and participants are a part.

This study adheres to the theoretical assumption that one's view of the world, and the meanings made from it, are constructed through interactions and social practices. Furthermore, the explanation of professional identity (as described in chapter 3) as a product of self-concept, social influence and professional affiliation, supports the selection of a constructivist research method to generate a theory that describes how the study's participants come to construct their world as they progress through the

transition from lay-person to professional person. The area of interest in this research is how the constructions occur at various points in this transition. The resultant explanation is not intended to provide a theory that can be used to objectively describe or to predict identity formation, but to present a candidate explanation of how undergraduate student nurses at two large city Universities underwent this process.

4.2.2 The role of the researcher in the study design

The assumptions of the constructivist grounded theory method are aligned to the aims of this study; where professional identity is viewed as being constructed through social practices of the university, the workplace and in broader societal structures. Furthermore, the position of the researcher, as a member of the same professional group as the participants, creates an opportunity for the researcher to get as close to the studied phenomenon as possible, whilst still being able to discern how meanings and actions might be connected to wider social processes, of which they may have little awareness (Charmaz and Bryant 2011 :p 293). As a registered nurse and an educator of undergraduate nurses, the researcher is able to remain sensitive to the nuances of the participants' narratives, which might be overlooked by an external observer. Likewise, as an educator, there is an awareness of the researcher's part in the ongoing construction of professional identity amongst the student nurses. This proximity of researcher and participant benefits the analysis by offering insights and interpretations that lead to a greater understanding of the phenomenon under investigation. These insights were written up as a Reflexivity statement (see section 4.6.4) prior to the analysis, and also through the production of memos during the analysis of the data. The inclusion of the researcher's insights and personal viewpoints in this thesis provides an audit of the researcher's position in these co-constructions. The researcher being a nurse educator and the participants being undergraduate students, emphasises a process of joint discovery about the development of professional identity. The potential for the researcher to have an influence on the participants' narratives- as a result of the researcher being perceived as possessing power within the relationship- is recognised within the findings and

analysis of the data. The positioning of the author within the process of data collection means that the aims of the study are best suited to the co-constructive strategies that are found in the constructivist grounded theory research design of Charmaz (2006, 2014, 2011).

4.2.3 Choice of data collection methods

Focus groups were chosen as being the most appropriate method by which to begin the exploration of the phenomenon. Focus groups are reported to facilitate discussion by bringing together a small number of participants to discuss topics presented to them through open-ended questions. It is then hoped that participants can feel free to share their thoughts with their peers (Kamberelis and Dimitriadis 2013). The environment of the focus group is more natural than that of an individual interview as the participants can influence, and be influenced by others in the group; mirroring real life interactions (Krueger and Casey 2009). Furthermore, the freedom of the group to lead the discussion towards topics of interest and importance, ensures that the participants' views are not be unduly forced by the researcher. The emphasis on the interactional processes of group discussion in a focus group is aligned to the constructivist assumptions of the research method. The opportunity to capture the self-disclosures, agreements and disagreements within group discussions reveal a range of perspectives and influencing factors by the individuals. The focus groups were followed up with individual interviews. This was an effective method by which a deeper exploration of the individual's experience could be made. Moreover, any additional perspectives that may not have been disclosed during the focus group, or might have changed over time, could be revealed. Through the use of focus groups- to make an initial exploration of the field- and by following up the participants at a later stage through individual interviews, the data reveals in-depth descriptions of the participant's professional identity formation. The data collection was subsequently followed by an iterative cycle of analysis and further data collection; in order to lay bare as much of the students' perceptions as possible.

4.3 Sample

The Grounded theory method can make use of purposive sampling techniques, whereby the participants of the study are selected according to certain criteria that are relevant to the aim of the research. With purposive sampling, participants are not selected in a random manner but instead are recruited on the basis that they possess particular characteristics that are of interest to the investigation (Bowling 2009). The participants recruited to the study were considered to be those that could offer insights into becoming a professional nurse, as they were those who were going through- and had observed this experience- first-hand (Morse 2007). The analysis of data gained from the sample group dictated the direction of subsequent lines of enquiry. Therefore, until the analysis of the data had begun, more specific criteria for participants' inclusion were unknown. The focus of the study is on the pre-registration phase of a nurse's career. Hence, participants selected for the study were those who were enrolled on a full-time undergraduate pre-registration nursing programme. Participants were taken from the programmes offered at faculties of nursing at two universities: one, a city-centre university and another located at the outer borders of that city.

Two types of sampling were used to select appropriate participants for the study:

1) Purposive- An initial sample of self-selected volunteers who were purposively selected on the basis that they met the criteria for inclusion; being undergraduate pre-registration student nurses in one of two universities. This sample was selected to

create a starting point from which further (theoretical) sampling would commence following analysis of the initial data.

2) Theoretical sampling- The same participants who had been recruited in the initial sample were used for more focused data collection, based upon the data analysis from the focus group data. The following sections of this chapter describe the details of the two research sites, the composition and characteristics of the sample group, the sampling considerations, and the recruitment procedures employed in this study. This is followed by a discussion of the ethical considerations associated with these procedures.

4.3.1 Research sites

The two universities were chosen as the research sites because they had different characteristics with regards to their location, entry requirements and the type of university as providers of undergraduate nurse education (see Table 4-1). It was anticipated that these two universities would offer the study an exposure to a wide range of student experiences, from which to begin the analysis. By deliberately seeking a broad range of student backgrounds and experiences across two different research sites, the aim was to increase the scope of the data collection and to discover a range of themes from which the study could proceed.

At the outset of this study, the influence of the education institution upon students' professional identity was not known. The existing literature did not clearly articulate whether there was an effect that different universities might have on the emerging professional identity. As such, the opportunity to gain insights from students at different universities was taken. The intention was not to specifically to make comparisons between the sites but to cast a wider net when gathering students' experiences.

Site 1	Site 2
Russell Group University	'New' (post 1992) university
Academic entry level: GCSE- 5 at C grade A Levels –3 at B grade (including a science) BTEC level 3 (2 distinctions and 1 merit) Access to HE course (minimum of 30 credits at distinction)	Academic entry level: GCSE- not specified A Levels –3 at C grade BTEC level 3 (1 distinction and 2 merit) Access to HE course (minimum of 18 credits at distinction)
Central city location	Outer city location
High research output (RAE 2008)	Medium research output (RAE 2008)
Student nurse population (~1000)	Student population (~400)
Average student nurse age- 22	Average student age- 24
Branches offered- Adult, Child & Mental Health nursing	Branches offered- Adult, Child, Mental Health & Learning Disability nursing

Table 4-1: Comparison of research site's characteristics

4.3.2 Purposive sample- Focus groups

An initial sample was formed from a population of undergraduate pre-registration nursing students at one UK city-centre university (research site 1). At this time, the undergraduate pre-registration student population was comprised of approximately 1000 students who were enrolled on one of the 3 branches of the programme: adult, child and mental health. It was important that a broad range of experiences, perceptions and participant backgrounds were included in the sample, therefore all students were considered to be eligible to participate in the focus groups. The only exclusion criterion for participation was that those students who were previously known directly to the researcher would be ineligible for recruitment, due to the potential risk of students feeling coerced into participating (see ethical considerations 4.3.4).

A total of 6 Focus groups were created from this population; 2 groups for each year of the programme. No limits were placed on the number of participants from each branch of the programme as it was important that no assumptions should be made about the possible effects that the student's branch might have on the data generated from these groups. Furthermore, as the aim of the focus groups was to explore general ideas and themes, if branch-specific concepts were subsequently discovered, they could be used to guide further data collection from participants on those branches during the individual interviews. The optimum number of participants for focus groups varies according to the aim of the investigation (Stewart 2007, Smithson 2000). Krueger and Casey (2009) claim that a focus group is traditionally

comprised of 10-15 members. However, they identify 5 criteria indicating that a smaller number can be used if:

- 1) The purpose of the study is to understand an issue
- 2) The topic is complex
- 3) The participants have a high level of experience or expertise
- 4) There is a high level of passion for the topic
- 5) There are a large number of questions to be covered

A target of 6 students per focus group was felt to be an appropriate number, based on these criteria. This group size is small enough to encourage participation from all participants and yet large enough to gain a wide range of opinions and experiences (Smithson 2000).

The first research site was chosen due to it being a well-established provider of nursing programmes. With its location in the centre of a large UK city, it has a large student population who are drawn to the university from a wide range of geographical and social backgrounds. This offered the opportunity to gain views about becoming a nurse in an environment where the nursing culture was prominent and well defined. However, following the analysis of the data from the first 6 focus groups, it was clear that a broad range of themes and concepts were emerging. It could not be established whether these emerging themes might be contextually bound to this particular university, or whether participants from other universities might offer alternative or similar perspectives. It was therefore decided to undertake further focus groups to enhance the data collection. Conducting another 6 focus groups in another university broadened the scope of the initial sample and ensured

that the data was rich. A further set of focus groups took place, this time at a second university on the outer borders of the city (research site 2).

4.3.2.1 Recruitment procedure at Site 1

The sample selection process began at the start of the academic year in September 2012. Access to the students was granted by the Head of the nursing faculty, the leader for the BSc programme was contacted to make arrangements to speak to the students at the start of lectures where all students from each year were present. The researcher briefly explained the purpose of the study and that participants were being sought to take part in small focus groups. Students from all branches of the pre-registration programme were invited to participate. Information sheets were distributed for the students to read in their own time. These sheets had a form attached, on which they were able to enter their personal contact details. These forms offered students the opportunity to participate, or to request further information. A large number of students completed the forms and returned them at the end of the lecture that followed the presentation. Others returned them via the internal mail system, or by hand to the researcher's office. In addition to this, an email was sent out to all undergraduate students. This email contained the same information as the printed sheet that had been distributed at the presentation. The email was intended to provide information to any students who missed the presentation, as attendance at these lectures was not mandatory. Two days were given as a 'cooling off' period before an email was sent out to all of the students who had volunteered their participation. Students were thanked for their interest and advised of a date and a time when the focus groups would take place. Participants were asked to confirm their attendance; giving them a further opportunity to withdraw their participation should they wish. As responses were received, participants were allocated into focus groups on a sequential basis. No specific allocation to any particular group was made

unless a respondent indicated that they would not be able to attend on the given time and date. A consent form was attached to the email so that the participant could print it out, sign it and bring with them to the focus group. The overall response rate following the verbal presentation of the study and the circular email was 13.2% (n=95) (see Table 4-2).

Cohort (year)	Number of students in cohort	Number of Responses	% response rate	Actual number of Focus Group participants
1	273	39	14.2%	9
2	222	24	10.8%	11
3	221	32	14.5%	12
Total	716	95	13.2%	32

Table 4-2: Site 1 recruitment response rates

Of those who had expressed an interest in participating, a further loss in the actual numbers of participants who attended the focus groups occurred (66%). This loss occurred where students initially expressed willingness to attend but then subsequently did not confirm attendance or acknowledge the email invite. However, there were sufficient numbers of participants available (32) to invite students to attend 6 focus groups; two per year group (see Table 4-3).

Focus Group ID	Year of programme	No. of participants
FG1	1	6
FG2	1	3
FG3	2	6
FG4	2	5
FG5	3	6
FG6	3	6

Table 4-3: Site 1 focus group participant numbers

4.3.2.2 Recruitment procedure at Site 2

The Dean of the faculty was contacted, and permission sought to access the students for recruitment. This was granted but with the caveat that they could only be contacted via email, as they felt that giving a presentation to the students prior to a lecture might be disruptive to the teaching staff. An email circular was sent out to all students which contained a link to an online form on *SurveyMonkey.com*; a third-party web-based utility for gathering survey responses. The website includes password protection and secure backup of data. The online form was identical to the information and participation forms that had been distributed by hand at research site 1 (see Appendix 7). Once the responses had been received, each participant was contacted by email or phone to answer any queries about the study and to arrange dates and locations for the focus groups. Response rate for site 2 was proportionally similar to site 1. Of the 400 pre-registration undergraduate students that were sent the email, 45 replied (11.3% response rate) (Table 4-4).

Cohort (year)	Number of students in cohort	Number of Responses	% response rate	Actual number of Focus Group participants
1	119	19	15.9%	11
2	133	10	7.5%	9
3	145	16	11.0%	11
Total	397	45	11.3%	31

Table 4-4: Site 2 focus group response rates

After loss to those who subsequently decided not to participate, a total of 31 students attended one of the 6 focus groups (see Table 4-5). The focus groups took place in classrooms in the university's main campus, where the students attended the majority of their classes.

Focus Group	Year	No. of participants
FG7	1	7
FG8	1	4
FG9	2	4
FG10	2	5
FG11	3	3
FG12	3	8

Table 4-5: Site 2 focus group final participant numbers

4.3.2.3 Sample characteristics

Both research sites offered Adult, Mental Health and Child Health nursing, site 2 additionally offered Learning Disability nursing. Students representing all branches participated in the focus groups. Both male and female students participated. A range of prior experience in health care work was evident amongst the population of students at both sites. This information was recorded so that it could be taken into consideration during the analysis phase. The final group sizes ranged from 3 to 7 participants with a total of 32 participants at site 1, and group sizes of 3-8 with a total of 31 participants at site 2 (see Table 4-6 for focus group sizes and characteristics).

Research Site 1	Year	Group ID	# participants	Branch				Gender	
				Adult	Mental Health	Child	Learning Disabilities	Male	Female
	1	FG1	6	5	1				6
		FG2	3	3				1	2
	2	FG3	6	5	1				6
		FG4	5	1	1	3			5
	3	FG5	6	6				2	4
		FG6	6	5	1				6
Totals			32	25	4	3		3	29

Research Site 2	Year	Group ID	# participants	Branch				Gender		
				Adult	Mental Health	Child	Learning Disabilities	Male	Female	
	1	FG7	7	3	2	2				7
		FG8	4	4				1	3	
	2	FG9	4	2	1		1	2	2	
		FG10	5	5					5	
	3	FG11	3	1	1	1		1	2	
		FG12	8	8					8	
Totals			31	23	4	3	1	4	27	

Table 4-6: Composition of focus groups across both research sites

4.3.3 Theoretical sampling- Individual interviews

Theoretical sampling requires the researcher to seek people, events or information that can develop the tentative theoretical categories emerging from the data (Charmaz 2014:p 345). The design of this study included a means by which the individual interviews were used to verify and develop emerging categories and concepts from the focus groups that had been collected from the previous cohort. For example: the individual interview schedule for the participants in year 3 included topics that were informed by the focus groups from third year students, performed a year earlier. Figure 4-1 (page 163) shows the data collection plan for focus groups and follow-up interviews at both sites.

All participants of the focus groups were contacted for a follow-up interview after 1 year. These interviews were performed individually and were semi-structured in nature. Although no new participants were recruited for the individual interviews, the emerging ideas were followed up with a different set of students who had already been recruited onto the study, as though they were newly recruited participants. Each of the participants from years 1 and 2 focus groups were interviewed as they reached the next year of their nursing programme. This allowed for any possible transformations relating to their professional identity to be explored. The participants of the year 3 focus groups had completed the programme and had left the university at the time of the individual interviews. Whilst it is recognised that the formation of professional identity is likely to continue beyond the period of pre-registration education, this study focuses on the process that occurs during the undergraduate

programme therefore, participants were no longer involved after graduation. Some of the focus group participants declined to be interviewed or had discontinued their studies during the year. One of the second-year students at site 1 who had initially expressed an interest in participating in a focus group, but was unable to attend on the day, contacted the researcher asking to take part in an interview. This interview was performed in the third-year of her programme. Table 4-7 shows the number of interview participants from each year across both sites.

Research Site	Year	Focus Group code	Focus group participants	Individual interviews (number)	Participant loss at interview (%)
Site 1	1	1	6	2	66.6
		2	3	2	33.3
	2	3	6	4	33.3
		4	5	4	20
	3	5	6		
		6	6		
Site 2	1	7	7	4	28.6
		8	4	1	75
	2	9	4	3	25
		10	5	3	40
	3	11	3		
		12	8		
Totals			63	23	

Table 4-7: Composite focus group and interview participant numbers.

4.3.4 Ethical considerations

An application for ethical approval for site 1 was submitted to the University research ethics committee in July 2012 and was granted in August 2012. An amendment to the existing ethical approval was made in January 2014 to extend the data collection to the second research site and was granted in February 2014. Certain ethical principles around the conduct of the study had to be addressed to protect the participants from harm, from manipulation by the researcher, and to maintain their privacy (Bowling 2009). Furthermore, the requirement for human participants to give their informed consent and to maintain their right to withdraw needed to be appropriately established within the study's design.

4.3.4.1 Non-maleficence

As with any research endeavour, the aim of the study is to generate knowledge that might bring about some benefit to others. The beneficence of this knowledge has to be weighed against any harm that might be caused in the process of generating that knowledge. Non-maleficence underpins the ethical approval process for each research study; ensuring that the participants are not harmed, and that any potential risk of harm is addressed. During the focus groups and individual interviews, the participants were asked to give their opinions and to describe their experiences about nursing. The interview schedule and focus group topic guide was not intended to lead the participants to reveal any emotive or potentially distressing information. However, because of the semi-structured nature of the data collection, there was always a risk that the discussion might lead onto topics on which could lead to the participants experiencing distress. Nursing can be an emotionally and mentally

challenging profession and the narratives of the participants might have presented an opportunity to reveal experiences that were laden with emotion.

As a safeguard against such situations, an independent, confidential counselling service was identified at each research site. Participants were advised of this measure on the information sheet, and verbally before their participation began.

4.3.4.2 Coercion

Measures had to be put in place to ensure that the students did not feel coerced into participating, or that they would be advantaged on their programme by participating. Likewise, participants had to be made aware that not participating, or withdrawing from the study, would in no way disadvantage them as students.

The researcher is also an educator, so there was a risk of being perceived as having a position of authority and influence over the students' success on the programme.

This might have led the students to feel obliged to participate in the study. During the recruitment stage of the study, it was made clear to the students that they would be a part of a personal PhD project, and that it was not directly connected to the programme upon which they were enrolled. It was also made clear that participation was completely voluntary and that their participation (or lack of) would not be revealed to any other members of the faculty, nor would it in any way influence the way they were treated in the future. This information was also included on the information sheet and consent forms (see appendix 3,4,5 & 6).

4.3.4.3 Confidentiality

In the focus groups and interviews, participants were to be asked for their honest opinions about their experiences of being a student and becoming a nurse. Their perceptions might have been critical of the nurse education process or their professional peers in clinical placements. For participants to feel reassured that their opinions would not compromise their status on the programme, measures were taken to protect the data collected from being accessed by anyone other than the researcher. Furthermore, the participants were asked to maintain confidentiality regarding anything that was discussed during the focus group.

The data collected was recorded on audio digital files for later transcription. On completion of the focus group or interview each file was transferred from the recording device to a password protected folder on the university network server and the original file on the recording device was permanently erased. As an additional measure, the files were anonymised using a code (e.g. FG1 or I2) to prevent identification of the participants' university or year of study.

All transcription was undertaken personally by the researcher. Any identifying information including participant's names were removed and were replaced by a code. A spreadsheet containing names, dates and identifying information of the participants was stored separately. Access to these files could only be gained by the researcher using a secure username and password.

4.3.4.4 Professional and legal concerns

The topic of the discussions in the focus groups and interviews related to the professional milieu of healthcare practice; where strict professional regulations by the Nursing and Midwifery Council of the UK (NMC) underpin the actions and behaviours of nurses. Although the data collection took place away from the clinical environment, the discussions would inevitably be concerned with experiences from the clinical placement areas. Hence, the ongoing responsibility of the participants and the researcher (who is a registered nurse)- to follow the NMC Code of Conduct with regards to confidentiality and disclosure- were adhered to. Participants were informed that, although their contributions to the study would be kept confidential, there remained a legal and professional responsibility for the researcher to take appropriate action if any professional negligence or illegal behaviour was disclosed.

4.4 Data collection procedures

As a research method, constructivist grounded theory follows the inductive, constant-comparative and open-ended approach that was described in Glaser and Strauss' original statement (Charmaz and Thornberg 2011). It is an iterative process between data collection and analysis that generates an increasingly refined theorisation of the data itself. The method suggests a cycle through several procedures that terminate once clarity is reached about the phenomena under investigation, or when no new concepts emerge from the data.

Grounded theory method is amenable to data from other sources such as case notes, existing research and quantitative data. In this study, where additional data was required (such as when participants made references to newspaper articles and media content), the researcher located these sources and included them in the data. Data collection was guided by the analysis of data from the initial sample. This was a more focused form of theoretical sampling whereby the criteria for sample selection became more specific as categories emerged, and the researcher's understanding of the developing theory increased (Morse 2007). The participants were asked to provide supplementary data (such as demographic information relating to their experience and background), then, as concepts and categories developed from the analyses, this supplementary data informed specific lines of enquiry. For example, when it emerged that prior work experience might have an effect on the way in which the student viewed the role of the nurse, it was possible to review the perception of other participants who had previously worked in care environments by

referring to this supplementary data. This process also facilitated the theoretical sampling procedure by allowing the researcher to include specific questions in the interviews with participants who possessed specific characteristics, for further data collection.

4.4.1 Focus groups

The data collection process started with focus groups as an open exploration into the substantive area under investigation. As professional identity is a broad and vague concept, and because the research design does not intend to pre-suppose what professional identity in nursing might mean to student nurses, general discussions about the role of the nurse and the perception of nursing as a profession was encouraged. Questions about their own and others' perceptions of nursing were asked to generate a more focussed exploration of how they see the role of the professional nurse in the context of contemporary healthcare. The primary purpose of these focus groups was to begin the exploration of professional identity by generating contingent categories based upon more generalised themes arising from the group discussions.

Each of the 12 focus groups was facilitated by the researcher using a standardised discussion schedule (Appendix 8), to ensure that each discussion explored similar issues. Although students were free to take the discussion in any direction that they felt to be relevant to the topic, cue questions were posed by the researcher so that more depth and clarity in the responses could be gained. A moderator was present at each focus group discussion to ensure that the discussions were facilitated consistently. The moderator was also able to make notes on the discussion, which provided an independent perspective on what was said and also highlighted aspects of the discussion that were not picked up by the researcher when there was more than one participant speaking.

The duration of the focus groups ranged between 35 and 55 minutes. University rooms were booked for each focus group. At site 1 this was a meeting room that was large enough for 8 people; at site 2, small teaching rooms on the main campus were used. The rooms were arranged in boardroom style so that all participants and the facilitator were able to address each other face-to-face. The moderator sat in the corner of the room out of the sight of most of the participants and did not participate in the discussion. No inducements or payment were offered to the participants. However, snacks and refreshments were provided during the discussion. Each focus group was audio recorded using an Olympus WS-311M digital audio recorder. This recorder produces audio files in the Windows Media Audio (.WMA) format in stereo, which was useful for identifying participants at different positions around the table during the transcription process. The recorder was placed on the table in front of the facilitator and, where possible, obscured from sight to help the participants to feel less self-conscious about being recorded.

4.4.2 Individual interviews

The interviews were informed by the data collected from the focus group in which they had participated, and also allowed for some comparison of data that arose from the focus group of the previous cohort (see Figure 4-1). For example, a second-year focus group participant was interviewed during the third-year of the programme. Perceptions of the nursing identity that arose from the second-year focus groups were then compared or contrasted with those at the time of interview; highlighting any transformations that may have occurred. These perceptions were also discussed as a comparison with those of the previous third-year focus group participants.

By following this method of data collection, verification and comparison of the participant's perceptions over time could be made; and these perceptions could also be tested against those of other students at the same stage of the programme.

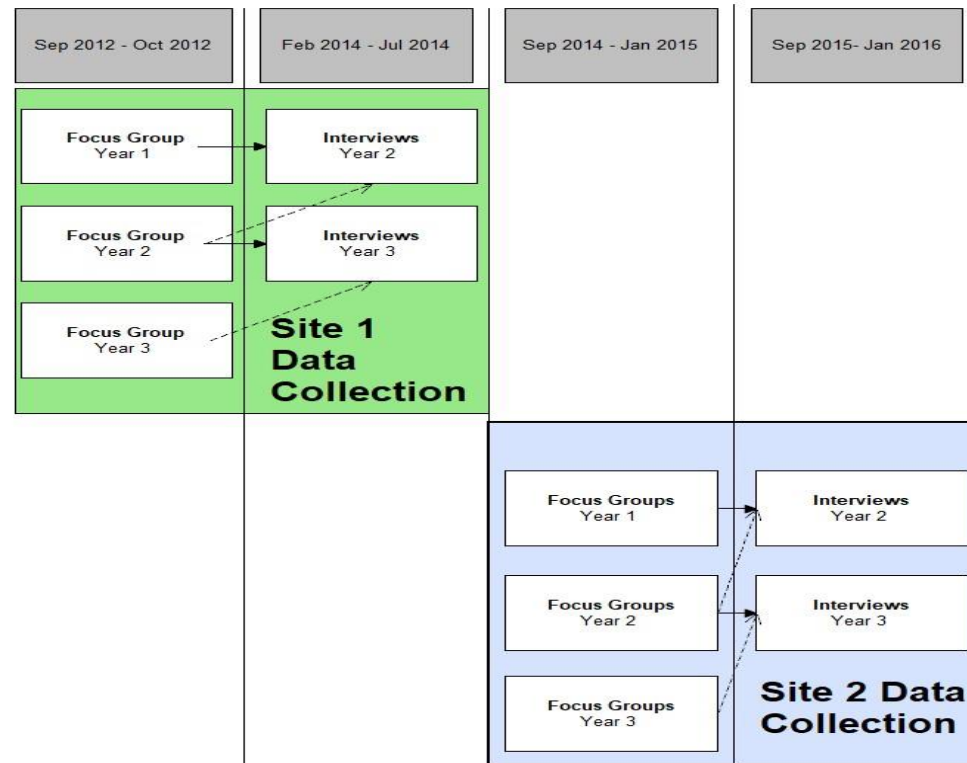


Figure 4-1 - Data collection plan

4.4.3 NVIVO 10 – Qualitative Data Analysis Software

The management of the data for this study utilised the NVIVO 10 software package. NVIVO 10 is qualitative data analysis software (QDAS) that has been designed for use with qualitative research where the researcher needs to manage, organise and visualise large volumes of data (Bazeley and Jackson 2013). NVIVO has the ability to work with various sources of data (text, audio, video and internet content) and can help to visualise the data through the use of built in modelling and cross-referencing functions. It was found to be particularly useful in this study when coding, categorising and comparing data with other data. Additionally, it enabled the formation of memos and journals about the emerging themes in the study.

4.4.4 Data handling and storage

All audio recordings were transcribed by the researcher personally using *F4plus* (version 5.2) transcribing software. This software facilitates the transcribing process by loading the audio file waveform into the software and allowing for the audio to be transcribed whilst stopping and starting the audio with a USB foot pedal. The transcriptions were formatted as Microsoft Word documents for ease of importing them into NVIVO 10. All transcriptions, audio recordings, notes, memos, participant lists, and analysis files were stored on a secure networked drive that could only be accessed by the researcher.

4.5 Data analysis

4.5.1 Initial coding

The focus group and interview transcriptions provided accounts of the participants' views and experiences about their transitions into the status of a professional nurse. The process of coding the transcriptions captured the emerging themes arising from the participant's narrative accounts. This was the first step in the data analysis as it facilitated the identification of important themes (in the form of labels) within the data. This early analytical procedure is referred to as *Initial coding* (Charmaz 2014). This was a line-by-line process in which the researcher tried to gain a sense of what was being said and adding labels to sections of the text. During this coding process, the researcher attempted to remain as close to the original data as possible whilst still remaining open-minded to the emergence of ideas and themes. This form of conceptual labelling of the transcript sought to inductively capture the essence of what had been said by the participant without unduly 'forcing' the categorisation of any theoretical perspective upon the data (Gibson and Hartman 2014).

In some cases, the participants generated conceptual ideas in their own words that were noted in case they could be useful for later analysis. These *in vivo* codes reinforced the importance of retaining as much of the participant's 'voice' in the data as possible. An example, from one of the 1st year student focus groups is shown in Figure 4-2, below. This was an *in vivo* code called '*Being a professional friend*'; a term that was used to describe her view on forming professional relationships with patients in the workplace. The related text in the transcription was coded with this

term and an accompanying text description was entered into NVIVO. These code descriptions were helpful to aid the understanding of the thought processes that occurred during the coding of the texts, as well as the context in which they were used.

<p>FG1-4</p> <p>You can't get too attached, no. You have to get that level of being a nurse not, well, and a friend, but not a...</p> <p>FG1-3</p> <p>A professional friend!</p> <p>FG1-4</p> <p>Yeah, a professional friend. (laughs)</p>	<p>CODES</p> <p>Avoiding attachment</p> <p>Being a 'professional friend'</p> <p>Being a 'professional friend'</p> <p>Being a 'professional friend'</p>
<p>(later in the discussion)</p> <p>FG1-5</p> <p>Going back to being a professional friend, it's kind of... people always say that patients tell nurses things that they don't tell the doctors.</p> <p>FG1-3</p> <p>Yeah, sometimes things that they've never told anyone!</p>	<p>Being a 'professional friend'</p> <p>Acting as a confidante</p>
<p><u>Code description</u> - Finding a balance between being a friend and being a professional. Building professional relationships whilst maintaining friendliness.</p>	

Figure 4-2: Coding sample- 'Being a professional friend'

Other sections of the text were coded without explicitly using the same phraseology used by the participants. Instead, an interpretation that captured the essence of the

text, was made by the researcher. In Figure 4-3, a code called '*Balancing professional relationships*' was created. During this initial phase of coding, codes were not combined with other codes as the process was not intended to start building categories of emerging themes at this stage. Charmaz advocates moving quickly through the text whilst creating initial codes so as not to start imposing concepts on the data too early in the analysis (2006). Figure 4-3 and Figure 4-4 demonstrate how, despite their apparent similarity (by both referring to relationships), these two texts created two separate codes (*Balancing professional relationships* and *Forming profound relationships*). The contexts of the statements were different; combining them at such an early stage might foreclose a future avenue for analysis. By attaching a description to these codes, the process of comparing the codes at the next coding stage would be made clearer.

<p>KI9-2</p> <p>You have to be caring but you have to see everyone individually as a human being and try to find the right balance between... obviously you cannot cross that line, you have to have a relationship because it <i>is</i> a relationship, but you cannot just cross the line as well, to get too close. It has to be in the right balance, but you try to maintain some kind of relationship. You cannot just say "ok, now I am just a professional and you are just the patient". There has to be some kind of 'click' in between that they will know "ok, I can trust you, I can tell you things".</p>	<p>Humanising care</p> <p>Balancing professional relationships</p> <p>Maintaining distance</p> <p>Balancing professional relationships</p> <p>Balancing professional relationships</p> <p>Gaining trust</p>
<p>Code description- Finding a balance between being a professional and maintaining a relationship with patients.</p>	

Figure 4-3: Coding sample- 'Balancing professional relationships'

FG5-6 [Nursing] is about a profound relationship you have with someone ... it's about human relationships and about that kind of thing. It's not about the tasks...	Forming profound relationships
Code description- Nursing is defined by the formation of 'profound relationships' with patients rather than by tasks	

Figure 4-4: Coding sample- 'forming profound relationships'

The detailed process of line-by-line coding opened up the text and helped to interpret the transcript in new and unfamiliar ways; testing the researcher's own assumptions (Strauss and Corbin 1990). Charmaz (2014) described *Initial coding* as fulfilling two criteria for completing a grounded theory analysis: fit and relevance. The codes created *fit* with the empirical world of the participants and yet allowed the researcher to crystallise the participant's experience as categories emerged. The resulting concepts, developed through the analytical process then retains *relevance* by interpreting what is happening; making implicit processes and structures visible (Charmaz 2014: p133).

4.5.2 Focused coding

The next coding phase was *Focused coding* when the initial codes were brought together to focus the data into themes and concepts. Thematic codes were also applied to larger sections of the transcription to make tentative interpretations of the participant's statements. This allowed for the movement away from the specific statements made to a more abstract conceptualisation of the data (Charmaz 2014). The process involved the use of the most significant or frequent codes from the *Initial coding* phase to go through and analyse large amounts of data. This required decisions to be made about which *Initial codes* could lead to categorisation and conceptualisation of the data (Charmaz 2014: p138). This decision-making process was supported by the use of annotations and memos within the NVIVO 10 software package (see memo extract 1).

One of the focus group questions asked was “What does it mean to be a professional nurse?”. The responses to this question were varied, but a theme began to emerge as an important component of professionalism: ‘*Acting the part*’. The students’ descriptions of these professional nurse’s actions seemed to highlight the perceived importance of being viewed by others (patients, peers, and friends) as a professional. There was breadth to these descriptions but there was sufficient similarity to start *focusing* the codes together into a conceptual category (see Figure 4-5). This demonstrates how the move from initial coding to focused coding was a process of bring to the fore some tentative conceptualisations based on what the participants were saying and bringing the data ‘into focus’.

Initial codes	Focussed code
Giving of the right vibes Exuding confidence Looking professional Presenting a sense professionalism Sounding professional	Acting like a professional

Figure 4-5: Focused coding sample- 'acting professionally'

In an extract from a memo that the researcher entered upon this observation, it is clear that the data was starting to ‘come alive’ as tentative concepts were being discovered:

“It is interesting how the students seem to concentrate on how a professional acts and behaves more than what they know, when asked about being a professional. Professional knowledge is mentioned but the primary focus is on how nurses are presented to the outside world. This includes their visible behaviours, such as using the language of the profession, acting in a compassionate way and looking professional (with or without a uniform). There are also some more tacit behaviours here, such as 'giving off the right vibes', 'exuding confidence' and presenting a sense of professionalism. All of these codes will be provisionally brought together as 'acting professionally' and I will review the data again for other examples.”

(Memo extract 1)

4.5.3 Axial coding

A third coding phase in the original GTM is *Axial coding*, which Strauss and Corbin describe as “the act of relating categories to sub-categories along the lines of their properties and dimensions” (Strauss and Corbin 1998:p 128). In the focused coding phase, initial codes were drawn together to form more conceptual categories. Care was taken during this grouping of codes not to lose sight of the nuance within the original codes. Axial coding ensures that the relationships between codes, categories and sub-categories are retained in this part of the analytical process. However, Charmaz (2006) suggests that axial coding, as described by Strauss and Corbin, applies a too rigid and formal framework to the data analysis and proposed instead that reflections on the categories and sub-categories take place to establish connecting links between them to make sense of the interview data (Charmaz 2006). Again, the use of memos during the analysis helped to keep an audit trail of the decisions made when handling coded data.

Following the focused coding process, the codes within each conceptual category were analysed and compared with each other so that the properties and dimensions of the concept could be explored. For example, the category of ‘Acting professionally’ was comprised of a number of codes, each of which described some different aspect of the concept. By coalescing these codes into an abstract category, the subtlety of the codes’ original meaning could be lost. By reviewing the codes and reflecting on their respective connection to the concept of which they comprised, the researcher was able to ascertain the breadth of the concept (its dimensions) and the particular defining characteristics (or properties) of the concept. The data revealed 3

distinct purposes for acting professionally, these formed the dimensions of the category:

1. Fitting in with peers
2. Meeting patient's expectations
3. Having a protective shield

These form the boundaries of the concept *acting like a professional*, as described by the students. The properties of each of these dimensions were then defined by the data within the codes that formed them (see Figure 4-6). This process brings back together the data that was fractured during the initial coding phase, into a more coherent whole (Strauss and Corbin 1998). Through this reflection on the initial codes, reviewing coding structures, comparing emerging categorisations and identifying the attributes and dimension of the emerging concepts, the axis around which the emerging concept is formed becomes clear.

Initial codes	Focused code	Dimensions	Properties
<ul style="list-style-type: none"> • Giving off the right vibes • Exuding confidence • Customer service • Separating personal and professional life • Presenting self as a professional • Sounding professional • Meeting patient's expectations • Wanting to be respected • Fitting in with the team • Hiding behind the uniform • Demonstrating caring • Appearing concerned • Smiling • Managing emotions 	Acting like a professional	Fitting in with peers	<ul style="list-style-type: none"> • Sounding professional • Wanting to be respected • Fitting in with the team • Exuding confidence
		Meeting patient's expectations	<ul style="list-style-type: none"> • Giving off the right vibes • Demonstrating caring • Appearing concerned • Customer service • Smiling • Giving off the right vibes
		Having a protective shield	<ul style="list-style-type: none"> • Hiding behind the uniform • Separating personal and professional life • Managing emotions • Presenting self as a professional

Figure 4-6: Axial coding sample

These reflections were documented as memos in NVIVO 10 so that explanations for each decision about categorisation and conceptualisation could be retained for later stages of analysis.

“With all of this talk about acting, I am left pondering a metaphor: if becoming a professional is being considered a form of learning to act the part (demonstrating professional behaviours, looking the part etc.), I wonder who is writing the script?

Where do these ideas about what a professional looks like come from?”

(Memo extract 2)

The questions that arose from these reflections were used in the subsequent individual interviews so that more could be learned specifically about these emerging concepts.

4.6 Rigour

Rigor is a way that trust or confidence can be established in the findings or results of the research study (Thomas and Magilvy 2011). Throughout the study, steps were taken to ensure that the resulting theory was rigorous. This was achieved by adhering to 3 core principles in grounded theory research during the collection and analysis of the data (Beck 1993). These are: Credibility; Fittingness, and Auditability.

The following sections describe how these principles were operationalised within the design of the study.

4.6.1 Credibility

The accuracy of the emerging concepts from the data- regarding their faithfulness to the respondents' descriptions of their identity as nurses- is essential for the resulting interpretations by the researcher being a credible account. The way in which the respondents described their experiences and articulated their views on developing professional identity needed to be faithfully conceptualised in the analysis. As a means of creating a level of abstract conceptualisation- whilst remaining faithful to the essence of the participants' descriptions- analytical findings were used to guide subsequent data collection. As concepts emerged from the data they were verified by modifying subsequent interview schedules, so that they could be confirmed and developed further, or refuted.

Verification of the data occurred through 2 processes:

1. Comparing data with data- by constantly comparing emerging themes from the data with other data, the researcher was able to identify similarities and differences. Where similarity was found, a stronger case could be made for supporting the described concept. Differences between data (where for example two or more participants' accounts superficially concurred but on closer analysis made different claims) these differences were noted in case they later be found to describe the dimensions of the same concept.
2. Triangulation of data- the individual interviews allowed for the data from focus groups to be checked against the interviewee's account.

Certain ideas and terms were identified in the focus group data that were considered to be relevant to the research aims. Where these appeared, the codes to which they were attached were then applied to the other focus group data through an iterative cycle of constant comparison. The following extract from a third-year student nurse at site 2 is an example of this:

*"I have been described as a party animal, I am quite fun and I am 'out there' and all the rest of it, and that does go into my work because I do a lot of laughing, I do a lot of smiling, I do a lot of chit-chat. And...with mental health, that goes down well. It's a smaller **circle of behaviour** than when I am outside but I did have an occasion where I was a bit too much of a party animal and it was affecting how people were perceiving me at work"*
(FG11-2 3rd year student)

The term 'Circle of behaviour' was used to delineate how the student acts in and out of her professional working role; recognising that her need to manage these behaviours was essential to the way in which she felt that her peers and patients viewed her. *Circle of behaviour* became an *in vivo* code which was subsequently used to review data from other respondents, where it was found that other similar views had been expressed. It was noted that a duality of conflicting identities was emerging as an important concept within the data. In a separate Focus group, another 3rd year student from site 1 described how the nurse's uniform facilitated the separation of these differing behaviours:

"I always call it the 'Jekyll and Hyde uniform off-uniform on system' (laughs) when I've put my nurses uniform on I am a very patient calm person and I'd like to listen to your problems and I'd like to help you. But when I'm in my jeans and my t-shirt I'm not a patient person". (FG6-2 3rd year student)

These participants guided the enquiry process in a way that ensured that their descriptions of professional identity shaped the future analysis of other data. The individual interview schedule was modified to include questions about nurse's behaviours in and out of work and/or their uniform, so that further verification, elaboration and testing of the concept could be performed. By ensuring that the researcher's conceptualisation of the data be kept as close as possible to the participants' responses enhances the credibility of the analysis to the extent that respondents should be able to recognise the researcher's description of their experiences as their own (Chiviotti and Piran 2003, Beck 1993).

The constructivist grounded theory method requires that the researcher becomes an important instrument within the research process itself. There should be no delineation between the researcher and the participants as it is assumed that they both share and construct the same social world. However, Chiviotti and Piran (2003) propose that the researcher should articulate their own personal views and insights about the phenomenon that is being explored. This, it is claimed, enhances the credibility of qualitative research by bringing to the fore the impact that the researcher is having on the analytical process. In this study, this was achieved in two ways: firstly, through the use of a personal journal describing the researcher's ideas and thoughts on the data; secondly, through the use of a post-interview comment sheet that was written by the researcher and the focus group moderators.

4.6.1.1 Using Memo writing to enhance credibility

Memo writing is an intrinsic part of the grounded theory method. The researcher makes frequent notes of the ideas, emerging concepts and links between codes and categories in these memos. This enables the researcher to capture reflections on the analysis that take place at all stages of the analysis which can then be revisited at a later stage of theory development.

In this study, memos were attached to sections of the transcriptions within the NVIVO 10 software package, particularly where the researcher's own personal thoughts and feelings on the topics being discussed might add analytical insights to

the data. An extract of a memo that was written in response to the extracts given above stated that:

“This idea has interested me! I can clearly recall as a practicing nurse those moments of putting on my uniform, or walking onto the ward and somehow feeling different. I’m not sure how much I changed as a person during those times but I do remember looking at myself in the mirror and thinking ‘do I look professional? Do I look like a real nurse?’. As far as my behaviours in and out of work were concerned, I recognise that there was a lot of modification that took place: I was clearly a more calm and patient person when around my patients, which was somewhat different to my behaviours outside of work. Having separate ‘circles of behaviour’ seems to be a very good way of explaining this”.

(Memo extract 3)

In order to enhance the credibility of the study and to limit the potential of overtly influencing the participants with the researcher’s pre-existing perspectives, these memos and post-interview comments were written after the data collection.

4.6.2 Auditability

In a rigorous grounded theory study, another researcher should be able to follow the methods and arrive at the same (or similar) conclusions (Carpenter-Rinaldi 1995).

However, in constructivist grounded theory method, this becomes problematic due to the role of the researcher as an ‘insider’. Here, the disclosure of the researcher’s

position, and openness about the decisions made during the analysis, are important elements of the audit. A consistent set of questions were asked of the transcribed interview and focus group data during coding and analysis. These questions- based upon the work of Charmaz, and of Glaser and Strauss' original work- were:

- 1) what is happening in the data?
- 2) What does the action in the data represent?
- 3) Is the conceptual label or code, part of the participants' vocabulary?
- 4) In what context is the code/action used?
- 5) Is the code related to another code?
- 6) Is the code encompassed by a broader code?
- 7) Are there codes that reflect similar patterns?

Clearly, these questions might yield different answers from different researchers, and the interpretations of the data might thus reveal different insights. However, the researcher's decision-making processes when working with the data (during categorisation, conceptualisation and theorisation) are made explicit through the use of memos and a personal journal. These demonstrate the 'insider perspective' and its impact on the interpretations of the data.

The provision of an audit trail was criticised by Morse (2002) as being no guarantee for the quality of the study's results, or the decisions made by the researcher.

However, documenting the course the development of the research design and the process of analysis affords the reader the opportunity to verify the veracity of the

resulting findings. Furthermore, Lincoln and Guba (1985) describe how an ‘auditor’ or second-party can review the research decisions and the methodological and analytical processes made once the study is completed, thereby confirming the findings. Clear explanation of any methodological or analytical decisions made during the study provide an audit trail so that an independent ‘auditor’ might be able to assess whether the study’s findings hold internal validity (Akkerman et al. 2006).

4.6.3 Fittingness

The findings of qualitative research inevitably are bound to the context in which the study has taken place. As such, the traditional notion of external validity holds little relevance to qualitative studies where the results are unlikely to speak to situations outside of the population and location from which they are drawn (Huberman and Miles 2002). Therefore, a workable reconceptualization of external validity for idiographic studies offers an opportunity for those reviewing the results to find some resonance (or ‘fit’) with their own experience of the phenomenon (Huberman and Miles 2002). The probability that the research findings might have some meaning in contexts other than that in which this study took place, has been referred to as it’s fittingness or transferability (Chiviotti and Piran 2003, Lincoln and Guba 1985). To fulfil this requirement, a detailed description of those who are being studied and the context in which the study took place should be offered so that the reader can make an informed decision about the relevance of the study’s findings to their own (Huberman and Miles 2002, Goetz and LeCompte 1981).

The description of the research sites, the characteristics of the participants (with regards to their gender, background, education and prior experience), the timing and the location of the data collection procedures are laid out in this chapter. As such, the reader should be able to visualise the context from which the theory has been developed (Chiviotti and Piran 2003). The reflexivity statement (written by the researcher during the study) is presented in the following section of this thesis. This insight into the researcher's position as a professional, which provides further context to the study and informs the reader's decision about the fittingness of the study's outcomes to their own context.

4.6.4 Reflexivity statement

My position as the researcher in this study is that of a professional ‘insider’, since there are several intersections of the social space that the participants and I occupy. Therefore, it is necessary to disclose how my interests, position and assumptions might influence the inquiry. This reflexive stance informs the reader about the decisions and the interpretations made during the conduct of the research.

I have had a professional interest in the role of nurses- their identities and the means by which these identities shape interactions between nurses and other professionals- since my own transition from clinician to educator in 2001. My position as an educator has allowed me to opportunity explore the transition from lay-person to professional through both formal and informal discussions with pre-registration and post-qualification students. These discussions have taken place in the classroom (as an adjunct to the teaching of professional knowledge) and in more informal discussions with students on an individual basis. An interest in who nurses are, the people that might want to become nurses, and in what kind of nurse students hope to become, relates partly to my own journey into the profession. Having begun my working life in an unrelated profession (mechanical engineering) and found myself, somewhat serendipitously in nursing as a mature student, I have long questioned the notion that nursing is a profession that you are born into, preferring to consider that nursing- as rewarding as it is- is a profession like any other. This is not to state that I lack passion and enthusiasm for nursing, or that I believe that everyone is capable of fulfilling the role, I do not. I understand that there are certain traits and abilities that are required in order to effectively meet the health needs of society. However, the

nursing profession has been shrouded in a mystique that often presents nurses as people who possess esoteric and exceptional gifts; my personal experiences of nurses as individuals contradicts this notion. Once much of the angelic imagery of nurses is stripped away, I see nurses as committed, intelligent and hard-working professionals.

As a male in a predominantly female workforce, my gendered position might influence my perspectives on the profession, and on the personality traits that nurses possess (or should) exhibit. I can only offer the perspective of a man in a society that is (unfortunately) still said to be centric towards male privilege. The reader is invited to interpret the effect that masculinity might have on my analysis of narratives arising from the subjective experiences of female student nurses. My experience of having worked in both male and female dominated occupations, I feel, affords me some insight into how these working environments differ, and how gendered differences influence the way that co-workers interact with one another. I am attempting to approach the data without duly enforcing such male and female stereotypes on the behaviours and attitudes being revealed. However, the success of this endeavour will inevitably be constrained by my own gendered outlook.

The intersection between my role as a registered nurse and as an educator of undergraduate nursing students may have an influence on the way that I am perceived by the students in the study. Whilst I might have my own experiences as a student (in the late 1980's and early 90's), that insight is undermined by the changes in nurse education since that time; changes that I have experienced as an educator, and not as a student. I have viewed these changes as positive moves for the

development of a modern professional, whereas a student struggling with undergraduate academic studies might perceive them less favourably.

My clinical background is in critical care, predominantly in Intensive Care nursing. Each speciality within nursing requires a unique skill-set in addition to the core skills that are expected of all professional nurses. Intensive care nursing is a highly technical environment that emphasises the manipulation of advanced medical equipment and a deep understanding of physiology, biochemistry and pharmacology. The ICU nurse must also be able to manage extremely emotional situations when working with patients and relatives. The intensive care nurse is in constant interaction with other healthcare professionals and the balance of power in clinical decision-making might be different to those that the students in this study have experienced. As a result, being a specialist nurse might affect the view of nurses as having a higher status within the multi-disciplinary team as a result of these more flattened hierarchies. These insights into my own professional perspectives are laid bare so that the analysis of the data can be clarified and better understood.

4.7 Summary

This chapter has outlined the case for the chosen methodology. Constructivist grounded theory has been demonstrated as the most appropriate method with which to meet the aims and objectives. The method offers the best ontological and epistemological fit with the study's aims. The data collection and analytical procedures have been described in detail along with examples of how these were operationalised in the study. Providing this detailed explanation of the analytical procedures meets two aims: 1) to explain the means by which the conclusions of this study were accomplished at, and 2) to facilitate the auditability of the procedures followed, so that the results of the study might be verified and accounted for. Coding examples have been included to demonstrate the procedures rather than to present analytical insights from the data. The following chapters will show in detail how these coding and analytical procedures have led to the conclusions presented.

5 Findings

5.1 Introduction

In this chapter, the analytical interpretations of the data from the focus groups and individual interviews will be presented. The organisation of the data into conceptual themes will be explained, along with an exploration of the interconnections between the concepts being described. The chapter will discuss some of the issues that are concerned with the type of data that has been collected, and the impact that this might have on the interpretations made. Chapters 6-8 will present the findings that are revealed by analysis of the data at three levels of social practice: Microsocial; Mesosocial; and Macrosocial. Each chapter will include extracts from focus group and interview data to illustrate the emerging themes at each of these levels of analysis. The extracts have been selected for their salience and representativeness of the emerging concepts. In cases where there are similarities between participants' statements, the dimensions of the concept are explained (as outlined in the axial coding procedure in section 4.5.3). Likewise, where participants described opposing or conflicting ideas, explanation is offered. Each chapter of findings will make reference to the longitudinal element of the data collection so that emerging concepts can be compared across various stages of the undergraduate programme.

5.2 Interpretations of focus group data

During the design process for this research, focus groups were chosen as a suitable method for uncovering the student's narratives through the medium of open discussion. As discussed in section 4.4.1, this was a semi-structured approach to the collection of data that allowed the students to raise salient points of discussion without being overtly influenced by the researcher to concentrate on specific topics. Furthermore, the use of focus groups encourages the participants to agree, disagree or debate the issues that are raised. Within the presence of their peers, the similarity of the viewpoints arising from each individual member of the group could be ascertained; thereby establishing whether an individual's viewpoint is consistent with that of the other participants. Whilst the intention here is not to quantify the frequency of which a given viewpoint is expressed during the focus group, having different viewpoints about a given issue could be uncovered, thereby broadening the data's scope. Analysis of focus group data is therefore different to that which is gained from the individual interviews. The discursive nature of the data requires the analyst to consider that more than one participant is involved in the interaction and that an individual's narrative might therefore be subject to some influence from the presence of their peers. Social conformity amongst peers might negate an individual expressing an opinion that could be considered to be undesirable or inconsistent with the expected social norm. Providing socially desirable answers is an inevitable drawback to this kind of data if the analyst is intending to uncover truthful statements. However, in the context of this study, where the dominant discourse is assumed to arise from the broader social practices, a participant's agreement with the

statement (even if they truthfully might disagree) highlights how these dominant discourses are powerful influences at the micro interactional level.

Throughout the analysis of the focus group data, a high level of agreement was observed between the participants of the focus groups. Often, when the participants were presented with an idea or a topic to be discussed, there would be a noticeable pause, during which the students would make frequent eye contact with other members of the group, as if waiting for someone to take the lead. Once an opening response has been made, it was noted that the other participants would either nod their heads or voice and affirmative utterance. This was recorded in a fieldnote from one of the later focus groups:

Once again, I spotted a certain reluctance for anyone to take the lead when responding to my questions. They don't give anything away but just look at each other momentarily with neutral expressions on their faces. It's as if some of the participants are worried about saying the wrong thing in front of the others. But, when somebody does speak up, the others are all quick to agree and become more animated.

(Field note from FG11)

This behaviour was more evident in questions that related to personal experiences. For example, the question "what did your friends and family say when you told them that you intended to become a nurse?". As this question required the participant to draw on experience that might have been either positive or negative, the reluctance to be the first to speak could possibly arise from a concern that the answer might reflect negatively on themselves or their friends and family. Such interpretations are

difficult to make. However, the question “what is your response to the negative media stories about nursing?” Elicited immediate and often strongly voiced opinions. Not surprisingly, the students overwhelmingly disagreed with their portrayal in the media. What was interesting however was that the immediate responses were short and vehement (“it’s rubbish”, “ridiculous!”, “A load of shit” etc). But there was, once again, a short pause before any of the participants offered any lengthy explanation about why they felt that these stories were wrong.

On very few occasions did the participants enter into any lengthy discussion between themselves about the issues raised. Where these interactions did occur between the participants, it was mostly in the form of agreement (“yeah, I agree”, “the same thing happened to me”, “that’s right”). In most cases, their responses were directed to the researcher rather than to each other. This could possibly be explained by the fact that the researcher is an educator, which might mean that their pre-existing notions about the normal relationship, and accepted behaviours- between an educator and students- could not easily be put aside; established roles of teacher and student require the acceptance of this particular social practice. Interestingly, when some participants were interviewed individually they explained that their viewpoint was actually different to those that were expressed by others in the focus groups. This was usually explained by fearing that there’s was an unpopular opinion.

5.3 Organisation of the findings

Once the data had been coded, and the codes organised into conceptual structures, it became evident that the codes could be categorised as either relating to *influences*, or to *processes* that describe the formation of the students' professional identity. In this analysis, influences are considered to be social structures that provide the potential to affect the individual in some way; existing externally to themselves. The processes, on the other hand, describe specific ways in which the individual makes sense of and responds to these influences. From these influences and through certain processes, the student then constructs a world view in relation to their emerging professional identity. This conceptualisation of the data is consistent with Berger and Luckmann's theory of social constructionism (1967). In this theory they describe the construction of the social world as being the way in which we create and then sustain all social phenomena through social practices (Burr 2015: p13). For the purpose of this analysis, the terms *influences* and *processes* will be used to represent *the social world* and *social practices* respectively.

As the data were coded, organised and categorised according to the emerging themes, it became evident that there were different levels of influence from which the participants constructed the professional identity of nursing as they progressed through the programme. These levels of influence represent different degrees of abstraction starting with the self-concept of the participant and extending through to the broader social world of government and professional regulation. Additionally, there were a number of influencing factors that arose from the immediate social world within which the student exists during the period of the programme; this level

of influence acts as a form of connection between the individual and the broader social structures that influence the profession as a whole. On identifying these levels of potential influence, the data were organised into three levels of sociological analysis: Microsocial, Mesosocial and Macrosocial. Figure 5-1 shows how the 3 levels of analytical abstraction relate to 6 broad thematic categorisations of the coded data. These categorisations describe the processes for identity formation that were revealed by the students in the focus groups and interviews. The italicised terms (*regulating, imagining, acquiring, connecting, perceiving, and presenting*) are gerunds that can conceptually define the key processes involved. Gerunds provide useful labels for the categorisation of codes that define actions or processes. Within each of these conceptual categorisations are a number of sub-processes that will be explored in the following sections. The arrows on the right-hand side of the diagram show the influences that are implied from the students' descriptions of these processes.

In the following chapters, each of these levels of abstraction and the processes identified in the data will be addressed separately as a means of organising and presenting the findings in a coherent manner. There are, inevitably, some interconnections and overlaps in these processes as a consequence of the different influencing factors that drive the processes. In some cases, the process of identity formation will refer to influences that arise from more than one level of analysis. This reflects the complexity of human social behaviour and that an individual's worldview cannot easily be reduced to simple categorisation. However, reference to these competing influences and overlapping processes will be highlighted where relevant to the overall aim of the thesis.



Figure 5-1- Categorisation of data by levels of analysis

6 Analysis of Microsocial processes

Microsociology describes a level of sociological analysis that is aimed at the individual's connections with their immediate social networks. Primarily, these networks are comprised of the individual, their family, friends and others in close proximity to the subject (Figure 6-1). Most of the questions being asked in the focus groups and interviews sought to explore the students' experiences and perceptions of becoming a professional nurse. Hence, many of their responses referred to themselves and the relationships that they had with those who were closest to them, such as friends, family, other students, and nurses that they encountered in practice.

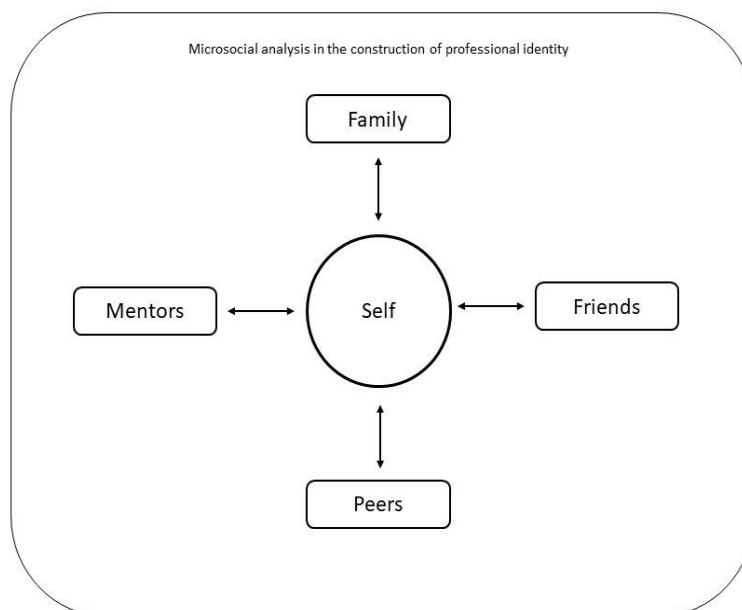


Figure 6-1 - Microsocial Analysis of Professional Identity

Students were asked about their individual motivations and their perception of themselves as a person, a student, and as an aspiring nurse. These discussions

revealed many important aspects about their self-concept and how this relates to their thoughts about what it means to be a nurse. The relationship between the student's self-identity and the professional identity of nursing, are described here as microsocial processes that are concerned with the negotiation of differences between self and profession. Where conflict arose between self and professional identity, means by which this conflict is resolved were described in the student's narratives. Perceiving themselves as a nurse (or wishing to become a nurse) reveals microsocial processes of self-management that are driven by a variety of influencing factors. These influences force students to evaluate themselves against their perceptions of the professional domain. The way that students perceive themselves as individuals, and how they present themselves in a professional context, provide rich descriptions of the personal transformation from lay-person to professional nurse, and the microsocial influences therein. The concepts of *perceiving* and *presenting* are closely related and yet offer distinct explanations about the effect on the individual as they strive towards, what they perceived to be, a professional status.

6.1 Perceiving self as a nurse

Discussions from across all the focus groups and interviews revealed the relationship between the way that students saw themselves and how they perceived professional nurses to be. Frequently, similarities were drawn between the students' personal attributes and their perceptions of nurses and were used as justification for wanting to enter the nursing profession. Being the 'right person for the profession' reflected the type of statements that might have been made by the students when being interviewed for a place on the programme. Providing these potentially desirable responses were noted most commonly during the first-year focus groups when the experience of being interviewed was still quite recent for them. These students were at the very beginning of the programme and mostly had very limited personal experience of professional nursing. Therefore, their comparisons of themselves were being made against a notion of what a professional nurse should be like, rather than from direct experience. However, some students described previous encounters with nurses (either as being a patient or from having friends and family in the profession) and used these as a reference from which they made statements about nurses.

Overall, the codes in this category describe the students' perceptions about nurses and the type of person that they feel that nurses should be. Reference to their own personal qualities were compared against the ideas that they held about professional nurses. These reflections gave them cause to reflect on their own suitability for the profession, or to consider the transformations that would be required for them to become the type of nurse that they thought they should be.

The categories, and the focused codes subsumed within them, for the concept of *Perceiving self as a nurse* are laid out in Table 6-1.

Microsocial Analysis	Perceiving self as a nurse	Being the right kind of person (section 6.1.1)	Being caring. Having leadership skills. Communicating with others. Managing under difficult circumstances. Describing the nurse. Nursing is your life. Having skills and knowledge. Giving oneself. Providing personal care. Helping the 'undeserving'.
		Perceptions of friends and family (section 6.1.2)	Prior insights into nursing. Validation and support. Experiencing negative ideas about nurses. Defending career choice. Correcting misconceptions
		Intrinsic motivations (section 6.1.3)	Wanting a valuable career. Developing self. Helping others. Learning more. Making a difference. Changing practice. Having varied career paths Feeling appreciated.

Table 6-1- Thematic categories: Perceiving self as a nurse

6.1.1 Being the right kind of person

Students were asked to describe the qualities that they associated with being a nurse. In addition to their descriptions of the work-role and personality characteristics of nurses, students also used this opportunity to provide examples of their own personal character traits. These descriptions were frequently offered as ways in which they described themselves as being the right kind of person to be a nurse. The similarities between themselves and professional nurses were provided as motivations and justifications for joining the profession. Importantly, these descriptors provide valuable insights into the kind of people that nurses were expected to be. The defining attributes were both affective (connecting with people on an emotional level) and functional (possessing specific clinical and professional competencies). Interpersonal skills, moral virtue and the ability to relate to others were described as personal qualities that the students had always possessed rather than skills that they acquired during the programme. It was recognised that interpersonal skills could be refined through exposure to clinical practice experience. However, they were claimed to be a pre-existing part of the student's personality that would be refined, rather than learned during the programme.

"I think that sometimes, when you come out of the hospital, you forget to switch off the 'nurse-mode'. Just yesterday, I was walking down the street and there was this man who had just been sick and he was just sitting there, so I went over and asked him if he was ok. Although I think I would have done that before anyway, it is now just second nature to go and see if

someone's alright. I like to think that I was always a caring person anyway but I think that nursing does make you even more so.” (FG10-1 3rd year student)

Students recognise that the desire to help others was already a part of their personality and that helping a stranger might have been an action that would have been considered before entering the profession. However, time spent as a student nurse makes this behaviour less of a conscious decision and becomes “second nature”. The experiences gained from being a student nurse and acting in the capacity as a nurse allows the student to adopt certain behaviours when the situation requires it (turning on the “nurse-mode”). This reflects an innate motivation to act authentically around others but also shows that there are different ways in which that authenticity is adapted according to the situation. This implies that an inherent capacity to care for others is somehow regulated; it being a mode of behaviour that is bound to work or non-work contexts, rather than a constant state of authentic behaviour. The management of behaviour- from caring nurse (in the hospital) to caring person (on the street)- becomes a sub-conscious decision as the behaviour becomes internalised through habitualised practice.

Being a nurse is described as a way of being, and not just the fulfilment of a work-role. The ‘right person’ for the profession is viewed as being intrinsically bound to the profession, with a consistent repertoire of behaviours, and range of personal attributes, that flow between the contexts of work and social life.

“it is not just a job it is a lifestyle, because you are a nurse, that is who you are. The nursing profession has made me who I am and I think that's great!

But I think it is a part of who I was anyway. I have always cared about other people so I suppose it was the right thing for me to do anyway. It was meant to be.” (KI1-1 2nd year student)

The predisposition of the student and the possession of certain personality characteristics are clearly stated (having always “cared about other people”) and provides a justification for the student’s career choice. However, a reciprocal relationship between the students’ character and their chosen career is also described. There is acknowledgement that some personal growth takes place as a result of being able to use existing qualities in a professional context. Descriptions of nursing as a life-style choice, and the inevitability that they would always end up in a career that makes good use of their caring nature, highlight a vocational dimension to becoming a nurse; distinguishing nursing from being ‘just a job’. Nursing was frequently defined using esoteric language that is akin to a spiritual calling, or destiny. Students felt that being the ‘right person for the job’ is more than possessing the appropriate educational qualifications, clinical skills, or knowledge for practice, it is an expression of the student’s personal ethical and moral values.

When asked to describe the attributes of professional nurses, responses were given in terms that primarily concentrated on the affective dimensions of practice.

Interpersonal skills, person-centred care and advocating on behalf of patients were given as examples that show how nurses need to engage with their patients on an emotional level. Students always referred back to examples of their own personal character traits to make comparisons with their expectations of professional nursing. that they felt to be consistent with these affective skills:

“I am such a chatty, bubbly person...I have always liked talking to people. People always come to me with their problems. Professional nurses have to be relatable like that I think.” (FG2-1 2nd year student)

“You have to remember why you came into the profession in the first place, you have to remember that you have to be person-centred. I always try to be there for them.” (FG8-4 3rd year student)

“Well, professional nursing is about helping everyone, isn’t it? Even those who can’t speak for themselves. I believe that everyone deserves to be cared for, regardless of who they are. Someone has to stand up for them” (FG1-2 1st year student)

Nursing is presented here as an extension of students’ self-concept; as a reflection of their authentic self. The students’ personal qualities, their ethical values and the ways that they viewed others were all given as the essential attributes of the professional nurse. The distinction between self-concept and professional identity were often blurred; being a nurse is a reflection of who they are and what they stand for. Furthermore, students explained how nursing gives them an opportunity to act authentically in a professional context, and for the benefit of others.

Being caring and caring about other people were strongly implicated as essential requirements for being a nurse. However, students also described caring as being a global human quality, that everyone should possess, not just nurses:

“I don't know, there's a little bit of a nurse in everybody, because everybody... there's a little bit of caring in everybody, it's taking care of people whoever they are, there is some element of care in everyone” (FG4-2 1st year student)

Nurses were held up as exemplars of caring behaviour that, despite nurses being characterised by universal ethical and moral values, were distinct in that they would demonstrate these behaviours whether they were in work, or not. The continuity of caring behaviours between the workplace and out-of-work life, highlight a perception that nursing is *who you are*, rather than *what you do*.

In the first year of the programme, students found that articulating the defining attributes of caring to be problematic, relying on abstract conceptualisations and reference to ubiquitous values and social norms. Being kind, compassionate, empathic and trustworthy were broad terms that were subsumed under the synonym of caring. Notably, first years made frequent references to promotional material that they had been exposed to when researching a career in nursing. Others made reference to keynote addresses made by the Deans of their respective universities during the first week of their programme. Several students described images of the caring nurse that they had seen in a promotional video from the RCN (‘This is Nursing’). In this video, a brief scene, in which a nurse places a cup of tea on a patient’s bedside table, seemed to resonate with the students’ ideas about caring behaviours. The symbolism of the nurse attending to a seemingly ordinary act, despite being otherwise busy, was a visual representation of a caring nurse for these neophyte nurses. First year students used the term caring with great frequency when

talking about nurses. Principally, they used caring in its adjectival form as a way of describing nurses, and themselves. However, second and third-year students used the term less frequently but did so by using the term in its verbal form (to give care) and adverbial (to perform tasks in a caring way). This change in the use of language indicates how the concept reflects changes to their perception of the nature of nursing work; caring becoming a function, or mode of practice, rather than a description of personal values. For these students, caring was used with more precision and often prefaced with contextual terms: Ethical caring, professional caring, inner caring, visual caring and un-caring. As students progressed through the programme, the term caring was replaced by descriptions of nursing that used more specific terminology such as *using self therapeutically* and being an *active listener*. Hence, over the course of the programme, students develop a greater understanding of the complexity of nursing practice, and the individual personal qualities required to be a nurse. With this knowledge they began to use language that more appropriately describe themselves and their work. Furthermore, caring had been transformed from a term to describe a ubiquitous human trait, to one that subsumes unique professional knowledge and more advanced nursing skills.

A strong sense of vocation is evident throughout the students' definitions of the nursing profession. Pride, passion and commitment were defined as essential elements for being a nurse. These definitions did not change over the duration of the programme, but the challenges faced in maintaining their commitment became more evident as students accumulated practical experience. In the first year, students did not anticipate that the programme would transform their personal values or change them personally; their only expectation being that they would acquire essential

knowledge and skills for practice. In the second and third years, students frequently reflected on how their own values had been challenged and were able to describe specific experiences which they had to negotiate. Organisational obstacles such as low staffing numbers and busy work environment threatened their ability to care for their patients in a way that they had not expected. However, students retained a commitment to be the kind of nurse that they wanted to be.

“I think that [the nurse] has to be someone that's a well-rounded individual ...compassionate, intelligent, caring, someone very patient and person-centred. It's hard when you are so busy all the time, but that's what we have to do. That's just nursing.” (KU 8-4 2nd year student)

Despite the students having an image of the nurse in mind, they recognised that the profession required new entrants that were suitable candidates to become nurses. One student raised an interesting question that others had alluded to; How do you ensure that the right people are selected for the entry into the profession?

“I think you get to know that [the other students] around you have very similar values, very similar, even though somehow, when we come to these interviews...it went so quickly, I'm like "how did you pick us?" out of the group of, what a few hundred? How did you know that we had the right quality to be a nurse? Because I think that, there's a lot of things about the university people recognising it... they have expectations, but I think that it's amazing that the university can just spot in an interview, in actually quite a short amount of time, that we're right for the job. But you look around and they're actually right, I work with some [students] in class and I'm like

"you're going to be an amazing nurse" and some of my friends that I've met, I know that they're going to be amazing nurses. " (FG4-1 2nd year student)

There was an implicit assumption made that the right people for profession were selected at interview, and that students do not start the programme as a 'blank canvas'. Each student commencing the programme was believed to be selected on the basis that: they were already in possession of the right qualities to be a nurse; that not just anyone can become a nurse; and that students are already on their way to becoming a nurse long before they commence their nurse education. In this extract, the student is surprised at how recruiters are able to identify the most suitable candidates in such a short period of time. But, at the same time, describes how she is also able to recognise those of her peers that, she believes, will be "amazing nurses". This reveals that there is a tacit understanding (shared by many people) about what kind of person a nurse is and what characteristics are required for a person to become a nurse. However, the origins of these assumptions- about who the 'right people' for nursing are- was not made clear.

6.1.2 The perceptions of friends and family

The opening question in the focus groups asked students to discuss the kind of reaction that they received from friends and family when they announced their intention to commence a career in nursing. The purpose of this question was to explore the general perceptions that people have about the nursing profession (whether they see nursing as a good career choice, or not), and also, to understand the impact (and possible influence) that these reactions might have had on the student's own idea about the nursing profession. The responses revealed a range of opinions that were received by friends and family with regards to the perceived status of the profession, and also what nursing's professional role entails.

Both positive and negative reactions to the decision of this career choice were received by the students. The responses to this question, and the discussions that arose from it, were followed up in the individual interviews that took place a year later. This provided the opportunity to explore whether these original perceptions were borne out by the student's experiences during the intermediate year, or if they had influenced their current notion of what it means to be a nurse. It was found that, rather than the student being influenced by the reactions of others, that they used their developing knowledge of the profession to refute negative perceptions and stereotypes about nursing. On the whole, nursing was perceived by others to be a profession that is associated with a high degree of worth and moral virtue.

Symbolically, the nursing profession was described in terms of serving a noble and useful function to society. However, these positive reactions were also combined

with interpretations by others about whether the student could be visualised as being the right kind of person to be a nurse.

“All of my friends were very supportive, and they were like 'thumbs up' for me, and all my family, they were very positive. All my friends who know me were saying, "Yes you will be perfect, I can really see you working in a hospital, and I wouldn't mind you touching me". So, I am thinking ok, if I have a green light from them it means that it has to be a good decision. So, I got positive opinions.” (FG2-1 1st year student)

The positive comments received, from the people closest to the students, about the nursing profession were based upon:

- 1) the symbolism of nursing being a virtuous career;
- 2) the breadth of career options and employment stability; or
- 3) the specific tasks associated with nursing; usually relating to aspects of personal care such as hygiene and toileting.

The intimacy that is associated with the relationship between a nurse and their patients was highlighted as a central characteristic of the profession as a whole and provided a reference point for comments made about the suitability of the student to become a nurse. Close friends and family recognised the compassionate nature of the student and made positive associations between them and the profession. In most cases, the student described how they had already made their decision based upon whether they considered the profession to be right for them. Therefore, these reactions had no impact on them. However, the validation that they received from

the supportive comments reaffirmed to the students that they were also right for the profession.

In cases where students had previously been employed in other occupations, comparisons between their former employment and the nursing profession were made. Notably, their previous employment was described as lacking in personal satisfaction, or in failing to make a positive contribution to society.

“I think that it's something that you can come into when you are a little bit older because you realise that you're not getting satisfaction from your life, and then you think "how can I get satisfaction from my working life?" and if you can get a lot of satisfaction from what you do then I guess it's sort of alluring.” (FG5-1 2nd year student)

The perception that nursing offers a high level of job satisfaction was an important motivation for the students. This motivation often superseded other factors, such as, employability, career progression and professional status. Having been employed in occupations that did not fulfil their desire to work with people, or made only a limited contribution to society, forced a re-evaluation of how they might make more satisfying use of their personal qualities. The varied roles undertaken by nurses, and the potential to use these professional skills in a wide range of contexts, presented students with a degree of job satisfaction that they valued above other factors such as salary and ‘normal’ working hours.

Several of the students revealed how they had found themselves in a position in which they were able to choose between undertaking a degree in nursing or a

medical degree, once they had completed their secondary education. Discussions about the decision to choose nursing over a career in medicine provided some interesting insights into their comparisons between the professional identities of nursing and medicine. In the discussions about this decision-making process, students revealed how they compared the social status of the two professions, the nature of the work-role, and the personal attributes of these two types of health care professional. Decisions about career choice between medicine and nursing were discussed with reference to coercive influences from friends, family and school teachers. The medical profession was presented to the students as being a more attractive career and an obvious choice for those who had the necessary qualifications. An exchange between three third year students demonstrates how the decision to choose nursing over medicine was met with negative reactions.

FG6-4- *"I've had, people going "why don't you just do medicine?" or people have said like "don't you feel wasted?". I was like "No! That's quite offensive to be honest". But then, they have no idea what nurses do. I don't think they have a clue".*

FG6-5- *"Yeah, I have had the "why don't you do medicine?" too. They just see nursing as not being as skilled and just seeing nursing as being belittled. It's not, it's a different skill-set.*

FG6-1- *"It's true, I think it just comes down to...I didn't want to be a doctor, and it was that simple, if you don't know what it entails then it's quite easy for them to say, "well you've got grades so you should be a doctor". I find it really easy to say, "I don't want to be a doctor!".*

FG6-5- *"They are different, you are kind of looking after things, there's a lot more patient contact with nursing. A nurse is there constantly the whole way through the day, attending to more of the patient's personal needs and psychological needs."*

(FG6 3rd year students)

Students defended their decision by stating that patient contact was a crucial factor in choosing a career that best fit their requirements for a satisfying profession. The idea that nursing held a lower status to the medical profession was used by friends and family to question the career choice. However, the students responded, not by refuting or correcting the statement made, but by justifying the decision, based upon the importance that they personally placed on patient contact. Defining nursing in terms of the proximity between nurse and patient, and the relationships that nurses build with the people under their care, was prevalent across all focus groups and interview data. The primacy of the nurse-patient relationship was held up as the most important characteristic of the profession, and the factor that made the profession appealing to them. Low pay, shift-working and the less glamorous task that nurses might undertake (notably toileting patients) were all cited as the negative aspects of nursing. But these factors were contextualised as being a necessary component of the nurse-patient relationship, which they always cited as being the essence of being a nurse, when defending their decision. Possessing the desire to build and maintain these relationships was also the essential quality with which students evaluated their own identity as a future nurse. They vehemently defended this aspect of their

personality and used it as a justification to exclude other professions as potential careers.

Negative perceptions about the level of knowledge required for nursing, in relation to other professions, were experienced by students before and during the programme. Students received surprise from friends and family about having to study at university to become a nurse. The image of nursing as a profession that does not require a high degree of knowledge seemed to have minimal influence on the student's own expectations at the beginning of the programme. Despite not having yet attended their first clinical placement, students had been made aware of the academic component to the nursing programme but seemed less sure about its importance when compared to practice learning. Knowledge for practice was viewed as important, but discrete from the knowledge that underpins it.

“Yeah, some of my friends were shocked that I was going to university to study nursing. They were like “can't you just do that at a hospital?”. I think the academic side of learning is important but you won't really know until you apply it on the wards, because people are so different. And it is learning to adapt to people's needs, and that only comes with experience. You can't just learn that from a textbook.” (FG1-4 1st year student)

The distinction between theory and practice was evident across all three years of the programme. However, by the second and third years, students became more aware of the need to develop an extensive knowledge base to practice effectively, and they had gained an understanding of what they deemed to be essential theoretical knowledge, and what was not. This extensive knowledge for practice was often

relayed to friends and family as a means by which the status of nursing as a profession could be defended, and their decision to become a nurse was justified.

"I was telling my friends about what we have been learning in uni and they were really shocked. They were saying 'oh my god, you have to know so much!'. I think they think that all we need to know is how to make beds and do bed baths. Of course, I didn't tell them that we got taught how to wash our hands in the first year! (laughs)"

(KU7-6 2nd year student)

The students' friends and family viewed nursing primarily in terms of its associated tasks, and its visible behaviours. Pejorative comments about 'wiping bums' and 'cleaning up poo' were commonly experienced.

"The general reaction was "oh you want to go to the ward and mop people's bum and clean their feet!". I think that's just the impression generally, from my experience that people have of nursing. Cleaning and hard labour-intensive work. And, I always found that I had to keep saying "oh, there are other sides to nursing". I always have to be telling people it's not just about cleaning bums, which seems to be a challenge I have to face all the time, because that's all they see, cleaning bums." (FG3-3 1st year student)

Students faced negative opinions about nursing being a low status profession because of its association with personal hygiene. However, they reconciled these negative influences by contextualising the less glamorous tasks within a broader framework of person-centred care; that personal care is a necessary, but small part of the job, and does not represent the totality of the role when caring for the sick. Students recognised that having to deal with vomit and faeces were inevitable

aspects of nursing, but they received differing interpretations from other people about how these tasks reflected upon themselves. They were either perceived as being exceptionally kind and caring- to be able to put aside any feelings of disgust so that they could focus on the needs of the patient- or they were confronted by the belief that such tasks were only performed by people who were incapable of getting a better job. In both cases, students rationalised these beliefs by assuming that most people are simply unaware of the true extent of the nursing role, and that the emphasis on the 'disgusting' parts of the job was entirely misplaced.

Considering themselves as being the right kind of person to be a nurse created a strong platform from which students felt able to challenge negative perceptions of nursing that they received from those closest to them. The processes describing the way that these reactions were managed involved the student taking a moral stance and realigning perceptions. Re-contextualising tasks as therapies through the use of alternative terminology was apparent. 'Wiping bums' became 'assistance with hygiene', 'feeding patients' became 'meeting nutritional needs'. Correcting the terminology used by others in this way, shows how students emphasised the therapeutic goals of pejoratively named tasks. By giving primacy to the importance of the care of the sick and helping others, the students were able to overcome the negative perceptions of nurses that were identified as: low financial reward; low social status in relation to the medical profession; performing unpleasant tasks; and not requiring a high level of education.

6.1.3 Intrinsic motivations

In addition to the way that the student might view themselves as being the right kind of person to be a nurse, and the processes by which this perception of self was used to counteract negative perceptions received from immediate members of the students' social group, students highlighted certain intrinsic motivations for wishing to become a nurse. By envisioning themselves in a professional sphere, they not only revealed insights into their self-concept, but also shed light on their perception of the professional group that they were entering. Their self-concept and their ideas about the professional identity of nurses were brought together, compared, and felt to be aligned with one another. Motivations that one might normally assume to be associated with becoming a professional (financial reward, status and authority) were absent from the students' discussions; rendering these assumptions as moot. Instead, the intrinsic motivations described by the students were focused on wanting a valuable career that is concerned with helping others.

The valuable contribution of nursing to society is an overarching theme that transcends all of the other intrinsic motivations described by the students. The perceived value of nursing in the provision of healthcare, and an assumed hierarchy with which importance is placed on the different professional groups' contribution to that provision, was clearly demonstrated by the students. Whilst they recognised a societal perception that the medical profession is primarily responsible for patient treatment, the nurse's contribution was explicitly deemed to be the most important element of patient care. Therefore, the value that students place on the nursing profession is contradictory to- what they believed to be- the public opinion about the

sovereignty of the medical discipline. Furthermore, this public opinion was felt to absolve doctors from criticism about their lack of patient contact time.

“But the doctors never get any flack for not spending time with the patients they just walk up to the bed have a 2-minute chat about how they're feeling and walk off, and no one says you're not spending enough time with the patients, but as soon as a nurse doesn't do it, the nurses are the ones that get criticised. But, the nurses are advising the doctors, but the doctors never get told they're not spending enough time with people.” (FG4-3 2nd year student).

The veracity of the claim that doctors are not criticised for lack of patient contact time might be questioned, but the idea that patient contact time is correlated with the patients' expectation of high-quality care, was commonly stated. Good and bad nursing practice was frequently evaluated with reference to how much time a nurse spends with their patients. Equating patient contact time with care quality demonstrates how the student justifies the significance of nursing to the overall provision of care. This then raised questions about why other healthcare professions are not evaluated by the same standards when concerns are raised about low standards of care. Students reflected on why doctors are not criticised for being more like nurses in this respect. Wanting to spend time with patients was viewed as privileged over other aspects of healthcare and offers insight into why the student is motivated to become a nurse; to fulfil a role that is seen to be the essence of healthcare.

The multidisciplinary nature of contemporary healthcare delivery was expounded throughout the student's discussions on a variety of topics. There was a recognition

that nurses are a part of a wider team of healthcare professionals, and that a synergistic relationship exists between each of these professional groups. However, even at the beginning of the programme, students had developed a perception that nurses are primarily responsible for ensuring that patient care is delivered in a humane and sensitive way. Nurses were frequently described as being responsible for providing advocacy for their patients and acted as an interface between patients and- what they described as- a medical profession that lacked a human touch. Therefore, nurses were described as providing an essential role that is unique amongst healthcare professionals due to the intimate nature of the nurse-patient relationship. This uniqueness was used by the students to justify their motivation for choosing a career that allows them to utilise their inherent capacity to show concern for others. Through their accounts, students emphasised their moral orientation towards the care of others, that is centred on human contact rather than simply treating disease.

The immediacy of the relationship between nurse and patient, did not provide the full explanation for why it was an intrinsic motivation to become a nurse. More specifically, making a difference to other people's lives through the formation of close relationships with patients, was also an essential motivation for students. Positively affecting the lives of others generated a sense of nursing being a satisfying profession. Where other healthcare professionals use their professional knowledge to establish treatment regimens for patients, nurses were described as making a difference to their patient's lives at an interpersonal, transformative and humanitarian level.

“I have learnt more about how to interact with patients because I'm a nurse and I want to help people, and I have learned that what I do with my patients can really make a difference to them.”(KI1-1 2nd year student)

The stories that students relayed about their experiences in practice often concluded by making a statement about how their intervention not only helped to treat a patient's illness, but more commonly they described how they positively affected the patient on an emotional level. Students narrative accounts were most commonly descriptive of how they helped patients through times of emotional distress; these examples were given as representations of nursing's unique contribution to patient care and not simply the delivery of medical treatments. This differentiation between interpersonal care and physical treatments defines the justification by which some of the students chose to become a nurse over joining the medical profession. Despite nurses commonly performing tasks that were previously the domain of the medical profession, and a recognition that healthcare is becoming increasingly technological, students still defined the professional nursing identity as being assigned to the role of delivering care that is affective and interpersonal. Students chose to give examples of the nurse's role that illustrate this apparently unique function.

At the beginning of the programme, students were orientated towards a profession that was concerned with improving the lives of individuals. However, towards the latter stages of the programme, students began to describe how they could also make a difference to patients' lives at a more strategic and managerial level. Having accumulated a significant body of experience in clinical practice, students had identified potential areas of nursing practice that they felt needed improving. By the

final year of the programme, students were beginning to describe the role of the nurse as a leader, and as an agent of change. Through the utilisation of their leadership and management skills, they felt that a registered nurse was best placed to address some of the apparent deficits in care that they had witnessed and heard about.

“I want to be a manager...I want to run the show now. I used to think that I would be happy just having my ward and having my patients and give them the best that I could. I have seen so many things in these 3 years that I think...you know, it shouldn't be like that, we could be doing things better. I have always been a bit bossy and I reckon that I was probably always going to be a manager anyway, but now I see that a lot of the wards I have been on just need a proper leader to make things different. So, I still want my patients to have good care, but now I want to be the one that is making it happen” (KI10-3 3rd year student)

As students started to envisage themselves as registered nurses, their ideas about the role of the nurse, and the contribution that nurses can make to health care in general (and not just to individuals), started to change. Their motivations to make a difference emerged as they reflected on examples of poor leadership and ineffective management in the clinical placements that they had attended. Some students recognised that they had a pre-existing capability to take on management roles. Others did not, but still recognised the importance of good leadership for improving care standards. Students with prior non-nursing work experience, in which they had a leadership role, described how they could transfer these skills to a new context so that care could be delivered more effectively. Others, with little or no work experience, also attempted to envisage themselves as a nurse who might transform

care delivery. Where the students felt that they might lack the essential qualities to be a manager, they nevertheless described the importance of all registered nurses being a part of a team that work cohesively together so that changes to patient care could be facilitated. Over the duration of the course, the students' description of nursing's professional identity was transformed from being primarily concerned with making a difference to individual lives, to facilitating broader changes to nursing care. The process by which this transformation occurred was based upon their reflections on the quality and effectiveness of the nursing care that they had observed in practice. Negative cases that had been highlighted in the media were also used as a motivation to drive this change, as students felt a need to defend the profession from criticisms about poor standards of care.

Students who had prior experiences of working in care environments expressed motivations that fell into one of three possible groups:

1) Undertaking care work was used as a means of testing out whether the career was right for them, or they were right for the profession. In this case there was a general notion that the profession might make a suitable career but they felt the need to experience it before committing to a demanding three-year degree course;

2) They had been required to attend a work placement as part of a further education course specifically designed for applicants to the nursing program who lacked the requisite secondary education qualifications;

3) They had been employed as a carer or had worked in a residential home (or other care environment) for some time before making the decision to enter the profession.

In the first case, curiosity and uncertainty about the desire to become a nurse is established. In the second, a decision had previously been made to follow a pathway

that would lead to professional qualification. In the final case, some students described how they had a long-term ambition to become a nurse but, for various personal circumstances, were unable to make the commitment. Others in this category, described how they became aware of the possibility of becoming a professional nurse whilst working as a carer, or were encouraged by work colleagues to make the transition from carer to professional. All of these cases provided the students with some insight into what might be expected of them as a professional nurse. References to their experiences and the insights gained from working with professional nurses were used as a means by which they described their perceptions of professional nursing. The descriptions of the nurses observed during these experiences were positive. However, these students were not always able to easily differentiate between the role of a healthcare worker and of a professional nurse, other than to describe the administration of medicines, organisation of care, and communication with doctors. The degree to which the experience of working in a carer environment provides accurate and relevant insight into the role of the professional nurse is therefore uncertain.

Imagining oneself as a nurse and undertaking the necessary preparation to make the transition from layperson to professional is based upon a number of factors. Students described how they considered factors pertaining to their intrinsic qualities, values and skills, and then referenced these against the image that they held in their mind of the professional nurse. Their target identity as a professional is therefore a product of their self-concept, their knowledge of the role, positive images presented to them by people who are close to them in their social world, and their personal experiences of having worked alongside professional nurses or being cared for by a nurse. The

multiplicity of these influencing factors makes analysis a complex task. However, the themes presented here show how self-concept is compared against a general understanding about the nursing profession and the role it fulfils. Perceiving oneself as a nurse was described by the students as a process which is primarily based upon evaluating oneself against a set of prescribed definitions of the type of person the nurse should be. However, the target identity, towards which the nurse establishes a trajectory at the beginning of the programme, undergoes challenges and transformations as real-world experience of nursing is encountered. These findings highlight a difference between the identity of the professional nurse and the identity of the nursing profession. The former being developed before entry to the profession, the latter being developed during undergraduate pre-registration education.

6.2 Presenting and managing self

Throughout the undergraduate programme, student nurses are presented with a number of clinical placement experiences during which they are socialised into the social norms of the professional world that they will enter. Exposure to a variety of practice experiences allow the student to immerse themselves in the day-to-day activities of nursing. During these activities, they observe the registered nurses that they are working alongside and make evaluations of their behaviours and their attitudes to their work and their patients. In the focus group and interviews, students provided extensive narratives of these practice experiences. Descriptions of their thoughts and feelings about their experience revealed processes that enabled them to identify and reconcile their self-concept with their perceptions of professional nursing. These experiences highlight four processes by which they, as individuals, come to terms with the challenges faced in the professional world:

1) forming relationships with patients; 2) managing the emotional challenges of nursing work; 3) presenting themselves as a professional; 4) personal transformations occurring during the programme.

These four processes are presented as thematic categories along with the focused coding from the data in Table 6-2.

Microsocial	Presenting and Managing Self	Forming relationships with patients (section 6.2.1)	Being a professional friend. Maintaining distance. Going the extra mile
		Managing emotions (section 6.2.2)	Being emotionally exposed. Emotional detachment. Caring too much. Separating personal and professional life.
		Acting like a professional (section 6.2.3)	Not showing true feelings. Presenting a professional image. Maintaining boundaries. Exuding confidence. Sounding professional.
		Personal transformation (section 6.2.4)	Facing challenges to self. Having values challenged. Developing protective mechanisms. Being changed by the profession.

Table 6-2- Thematic Categories - Presenting and Managing Self

6.2.1 Forming relationships with patients

Students place the relationship that nurses form with their patients as being the central reference point from which they make evaluations about individual nurses, quality of nursing care delivered and the image that they hold of professional nursing. This relationship is defined using terms that describe it as an intense emotional connection that is created through the time spent with the patient and the quality of the interaction during that encounter. Students frequently referenced this relationship as being the significant difference between nursing and other healthcare professions. The idea that it is this relationship that so accurately defines the contribution of the nurse to the patient's health and well-being, arises from images of the nursing profession that students had encountered prior to, and during the early stages of the programme. Students' discussions with friends and relatives who had been nurses, or from having had experience of being cared for by a nurse, led to an evaluation of nurse's behaviours that focused on nurses' humanity, compassion, friendliness and advocacy.

Examples were given of times when nurses had stepped outside of normal working practice through gestures such as allowing a visitor onto the Ward outside of normal visiting hours, on an occasion when an anxious relative had been stuck in traffic. These exemplars reinforced to the students the importance of acting in a way that demonstrates concern and compassion for those who would otherwise feel depersonalised by being a patient. By focusing on stories that describe patients as people, rather than a diagnosis, students would present nurses as the 'human face' of healthcare; individualising people rather than deindividuating patients. Students

would highlight certain exemplars of nursing practice that resonated with their own ideas of what nursing should represent and how these behaviours mirrored their own personal values. A counterbalance to this humanisation of patients by nurses was often provided by making reference to the medical profession. The brief, medically orientated interactions between doctors and patients were viewed negatively as they were evaluated against criteria that were normally associated with nursing practice. Whilst it was recognised that doctors and nurse's roles are bound to the same overall healthcare aims, the objectives by which these aims are achieved were clearly differentiated. Notwithstanding this differentiation, students negatively evaluated the doctor-patient relationship by referencing the difference between it and the nurse-patient relationship. The medical focus on curing disease was felt to come at the expense of loss of individuality for the patient. Nurses were perceived to fulfil an essential role by re-establishing a balance between curing and caring.

"I think, as a nurse, you just get to know your patients more, like doctors can go around and see 40 patients in a day and not know anything... forget the name after five minutes, but a nurse can be working on a ward with six people for six weeks and you just get to know everything about that person, and that's the one that sold [nursing] to me, like, that's why I wanted to do it, I actually wanted to know the people I was caring for, know the people I was treating." (FG1-5 1st year student)

Knowing the patient at a deeper level, was described as being an appealing aspect of professional work for the students. By viewing themselves as person-centred, students were able to recognise how their own personal qualities resembled those that are expected from nurses. Furthermore, those nurses who were deemed to be clinically competent, and in the possession of substantial medical knowledge, but

lacking in interpersonal skills, were viewed negatively by students. Nurses undertaking medical roles was considered to be a part of the nursing profession's changing scope. However, where nurses undertake these roles without retaining a sense of person-centredness, they were treated with suspicion.

“Well I think that there are fewer doctors than there used to be, and they are much, much busier, and some people think that we are supposed to pick up the slack. You know, it's like we are supposed to become mini-doctors, but we are already busy, and we can't keep doing all this extra stuff. At the end of the day, we are nurses and we have to get on with what we are doing, with the patients. I think that some people think that we should be grateful that we are being allowed to do doctors jobs, like it is some kind of treat for being a good nurse, but it's not like that, our role is different and we have to concentrate on being with the patient, and not faffing around with a load of extra paperwork” (FG10-4 3rd year student)

Incorporating roles that are associated with the medical profession into the nursing repertoire was considered to be inappropriate unless the student saw a direct benefit to the patient, or if the nurse is able to perform those tasks using their own sense of care and compassion.

The students described the myriad ways in which nurses engage with their patients. Primarily they framed these descriptions in terms associated with friendliness. Being a friend to the patient, albeit on a professional level, allowed the students the opportunity to gain a deeper understanding of the patient as a person. Knowing the patient in this way, provides a platform from which students were able to identify

specific care needs for individual patients. This friendliness is therefore a mechanism by which students feel empowered to advocate the patient's wishes and preferences when discussing care plans with qualified nurses and other healthcare professionals. Another dimension of this friendliness was described as a means of breaking down barriers between the patient and a healthcare system that might induce fear and anxiety. This engagement with patients, through the use of interpersonal skills, is a process by which students felt that they were able to use their own individual personality to present themselves as caring, compassionate and acting in the patient's best interests. Appearing friendly was also cited as a useful tool with which nurses can induce compliance and adherence to medical treatments; particularly when dealing with children, people with mental health issues, or situations that are emotionally charged.

“a lady who came in on her own accord with mental health issues and no one really wanted to do anything, she was running around the department trying to break into rooms and she ended up just sitting on the floor and burst into tears, and I said “look, don't run away, it'll be worse, the police will come and get you, you will be dragged back in” and I was like “look, do you just want a hug?” so I gave her a hug, held her hand, walked her back to her bed, she went back to her bed and went to sleep. And, actually some people might say that it is probably not professional, giving her a hug, but it helps her treatment, that's all that matters really” (FG5-4 3rd year student)

Offering friendship to patients was sometimes exemplified as “going the extra mile”, or “being flexible” with regards to normal regulations and working practices. This flexible approach is normalised by the students and considered to be an essential part of the nurse’s role. However, as the programme progressed, students recognised that this flexibility can become limited by the constraints of time and staffing pressures, which impact on normal working practices.

“When I came into nursing I thought that I would be the one to go that extra mile to help the patients, not just keep them alive but find time to sit and talk with them to really help them, and I have always tried to do that but it is tough when you are so busy and there are other nurses who think that that is just a waste of time. It’s hard as a student nurse to stand up to them and say “no, this is important”, so you sometimes just go along with it. But I know that’s not how I want to be” (KI10-2 3rd year student)

Students at the beginning of the programme associated good nursing practice with the ability of the nurse to freely create relationships with patients in ways that are consistent with their personality type. The difference between their self-concept and their identity as a student nurse, overlap to a large extent. Students from the second and third years describe how this overlap becomes smaller as they identify means by which they need to separate being a friend from being a professional. The term “being a professional friend” was used by a second-year student to describe the process of exhibiting friendliness and yet still presenting a professional outlook (Figure 4-2). Finding a balance between these two seemingly contrasting attitudes was widely described by students. The justification for managing relationships with patients in this way, arose from the need to satisfy the demands of the professional role, whilst also retaining an attitude towards patients that students considered to be

essential to the professional identity of the nurse. Clinical placements, where local working practices allowed students the opportunity to forge strong relationships with their patients (as a result of the team culture or the slower pace of patient throughput), were positively evaluated by students and identified as examples of good nursing practice. In clinical areas where the team culture did not value patient interaction, or gave it a lesser importance than the students, negative views of those nurses were described.

In the early stages of the programme, students described nursing's professional identity in terms of affective and interpersonal behaviours. Associating the nursing profession with being caring and compassionate reinforced their need to present themselves as authentically friendly with their patients. The transition into the latter stages of their professional socialisation required students to manage the balance between friendliness and flexibility, and between professionalism and productivity. Situations where nurses failed to maintain this balance were described as examples of poor nursing care. The value of spending time with patients and forging relationships with them, was never lost by students, but with experience, students soon recognised that allocating additional time to individual patients was idealistic and largely unachievable. Patient contact time became a resource which had to be allocated evenly and fairly when constraints on time occur. The practice of allocating time to patients for purposes other than the delivery of direct nursing care (hygiene, administration of medication, changing wound dressings etc) was described as being dependent on the prevailing culture of the clinical environment.

The leadership of the nursing team was frequently cited as being central to the local nursing culture where more, or less value is placed on forming relationships with patients. Students adaptation to local culture, for the purpose of “fitting in”, varied according to their own personality type. Some students described their resistance to conform to behaviours that they perceived to be outside of their expectations of the nurse patient relationship. Negative comments were sometimes directed at students about not ‘wasting’ time spent talking with patients. These were regarded as examples of poor practice and lack of commitment from the nurses. Other students felt less able to act in a manner that was contrary to the local culture and accordingly adapted their practice by emulating the behaviours of other nurses in the team. In these cases, students described the anxiety that arose from this disconnect between what they perceived to be a priority, and what the local working practices dictated. With experience, students at the end of the programme described how they had gained sufficient confidence to be more self-determining about how they balanced the development of personal relationships with patients, and the management of their clinical workload.

Despite the importance placed by students on the formation of interpersonal relationships with patients, they also described situations where active detachment (or professional distance) was required. Students described this distance that they created between themselves and their patients as a part of “being professional”. This was differentiated from examples where distance between nurses and patients occurred as a result of the nurse lacking care and compassion. Increasing the professional distance between the patient and themselves was, at times, seen as necessary for the student to complete their work, to protect themselves from over

attachment, and distributing nursing care evenly between a group of patients.

Hence, professionalism is not seen as a static or fixed concept, it is flexible, dynamic and contingent. Across all three years of the programme, students were asked to define what they considered professional nursing to be. Additionally, in the individual interviews, students were asked to describe the kind of professional nurse they aimed to be following registration. The responses revealed two different ways in which professionalism can be defined. Firstly, that it is the strict adherence to the professional code of conduct; a rigid framework of practice that is required for remaining on the professional register. Secondly, it was defined in terms of moral virtue, attitude and behaviour towards patients and other healthcare professionals.

“you have to have your eyes open, you have to be caring but you have to see everyone individually as a human being, and try to find the right balance, obviously you cannot cross that line, you have to have a relationship, but you cannot just cross the line as well, to get too close. It has to be in the right balance, but you try to maintain some kind of relationship. You cannot just say "ok, I am just a professional and you are just the patient". There has to be some kind of click in between that they will know "ok, I can trust you, I can tell you things". Obviously making sure that it is not crossing the line which you have probably in the code of conduct.” (KI9-2 3rd year student)

Professionalism was defined as being a technique that is used circumstantially; students judge the situation to decide whether it was appropriate to use their own set of personal behaviours whilst undertaking their work. Students described the balance between *being yourself* and *being professional* whilst caring for patients, as

intuitively ascertained. Students recognised, what they considered to be, professional behaviour in other nurses, when they observe that an appropriate balance has not been maintained.

“if you see something that's unprofessional on the ward, you can make your own assumptions, and say "I certainly wouldn't do that, that's unprofessional", that's forming an opinion, I think that the majority of times, when you see something unprofessional is because you have a gut feeling that it's wrong. Which again is just, it's not the profession at all, it's you, as a human being, beyond the profession, that knows what's wrong and what's right. And so, then you've got your own personal opinions coming in to play and your own ethics and not just the profession's ethics.” (KU3-6 2nd year Student)

Balancing the distance between the personal and the professional self was also exemplified in students’ discussions about the use of social media. All of the students who participated had been warned by their respective universities about the disciplinary action that might be taken against students who demonstrated unprofessional behaviour on social media sites. Furthermore, students recognised that having their personal lives on view to the public might have an impact on how they are viewed professionally. In this respect, preventing patients from gaining uncontrolled access to the student’s normal life outside of work, was sometimes viewed as contradictory to their intention to present themselves to their patient’s as being genuine and friendly. And yet, considered necessary so that students could present themselves in a professional light when required. As they progressed through the programme, students revealed how they became more autonomous in negotiating the boundaries of professional practice. Balancing authenticity in their relationships

with the requirement to adhere to professional rules. This autonomy of professional behaviour highlights a way in which their identity as a nurse becomes a managed process in the context of the nursing's professional identity.

6.2.2 Managing emotions

By the end of the programme, students were describing, in detail, situations where they found it necessary to withdraw behind a professional shield and to limit the extent to which they engaged with their patients emotionally. By detaching emotions from some situations, students found that this would limit their potential to be exposed to emotional harm, over-attachment and burnout. In their interviews, students were asked to talk about situations where they felt that they had been challenged emotionally and how they managed these situations. The students described how they attempted to leave their emotions behind them when they left work but stated that, in many situations, this was neither possible or even desirable. The high level of emotional intensity associated with some clinical situations had a lasting effect on the students. Often, they used the time between leaving work and arriving home (or the time immediately after arriving home) to reflect on the day's activities so that they could resume their normal lives as soon as possible. Students also felt that being affected emotionally by the challenges of nursing work is a positive sign; that they care enough to still be an emotionally affected even after they have left work.

The relationship between being at work and wearing a nurse's uniform was used as a metaphor for taking on the emotional burden of caring for the sick. Many students described the putting on, and taking off, of the uniform as being analogous with donning the mantle of a professional nurse, particularly at the beginning of the programme. However, interviews with students at the end of the programme revealed how the uniform became less associated with being a nurse.

“When I take my uniform off, I don’t stop being a nurse anymore. I remember that I used to be an ‘in-out’, ‘on-off’ kind of nurse, you know? When I had the uniform on I was a nurse, but it came off I was me again. But now, in my head I have it on all the time, even if I am slobbing around at home in my pyjamas. Because I am always thinking about stuff that happened on the ward... I’ve seen too many horrible things lately for me to be able to just forget about them as soon as I take my uniform off” (KU9-4 3rd year student)

The students recognised the potential harm that might befall them should they become too close to their patients. The risk of over attachment to patients and their family presented students with an increasing challenge as the programme progressed. Nurse’s attachment to their patients had been prized as a valuable, and essential, part of nursing’s identity, in the first year of the programme. However, students soon learned about the inherent dangers that this might have to their own mental health. Students described *Not Caring*, *Caring*, and *Caring Too Much* as points on a continuum that mirrored their definitions of *bad nursing* and *Good Nursing* respectively (Figure 6-2).

“some nurses I’ve seen just aren’t [caring] and you try and ask around that subject and they are just like “I’m too busy” you know? I got told on one of my placements my main problem is I care too much about them and that takes up far too much of my time, and I was just like “well, how is that a negative thing?” (FG5-3 3rd year student)

Bad nurses were perceived as being emotionally detached, uncaring, and easily able to leave work behind them at the end of the shift. Whereas, examples of positive role

models that the students described, lived the role of the nurse whether at work or not; demonstrating an above average level of care and compassion.

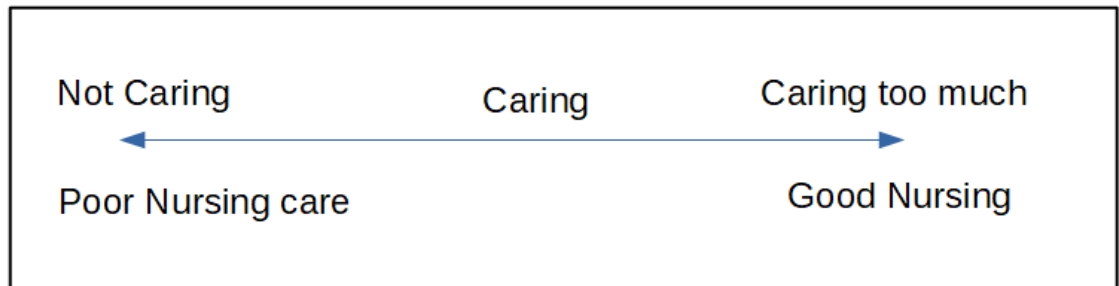


Figure 6-2- Relationship between Caring and Nursing Quality

Students perceived that patients expected nurses to invest in them emotionally, and not simply to demonstrate professionalism.

“I think that it's a bit of a blurred line though because, the patient expects you to be that shoulder to cry on and a sort of friendly face, more so than the doctor. And they want to talk to you and stuff, so you can't just be this cold clinical person doing everything by the book. I mean obviously you should but, it's difficult, the public wants someone who they can come to and cry to and, and talk about things, and talk to you in general. But at the same time, we've also got all these other things to uphold, I don't know, it's a bit of a blurred line.” (FG5-3 3rd year student)

The students interviewed found it difficult to articulate specific processes by which they could maintain professional standards, meet patient’s expectations, and also develop these deep emotional connections with their patients. Each of these demands were viewed as important aspects of professional nursing and yet, were often found

to be difficult to achieve simultaneously in clinical practice. Student's narratives focused on how each of these elements defined 'good' nursing in different situations, but they conceded that one, or two could be achieved, but always at the expense of the others. These three distinct, yet interrelated patterns of behaviour represent different aspects of what they believed to be characteristic qualities of nursing. Professional nurses were observed to be orientated to one or more of these behavioural patterns that reflect their individual personalities. It was possible for nurses to adopt any of these behavioural repertoires when required but their personality would always de-emphasise one in favour of the others. Figure 6-3 provides a visual representation of this Triad of professional nursing behaviours that the students described.

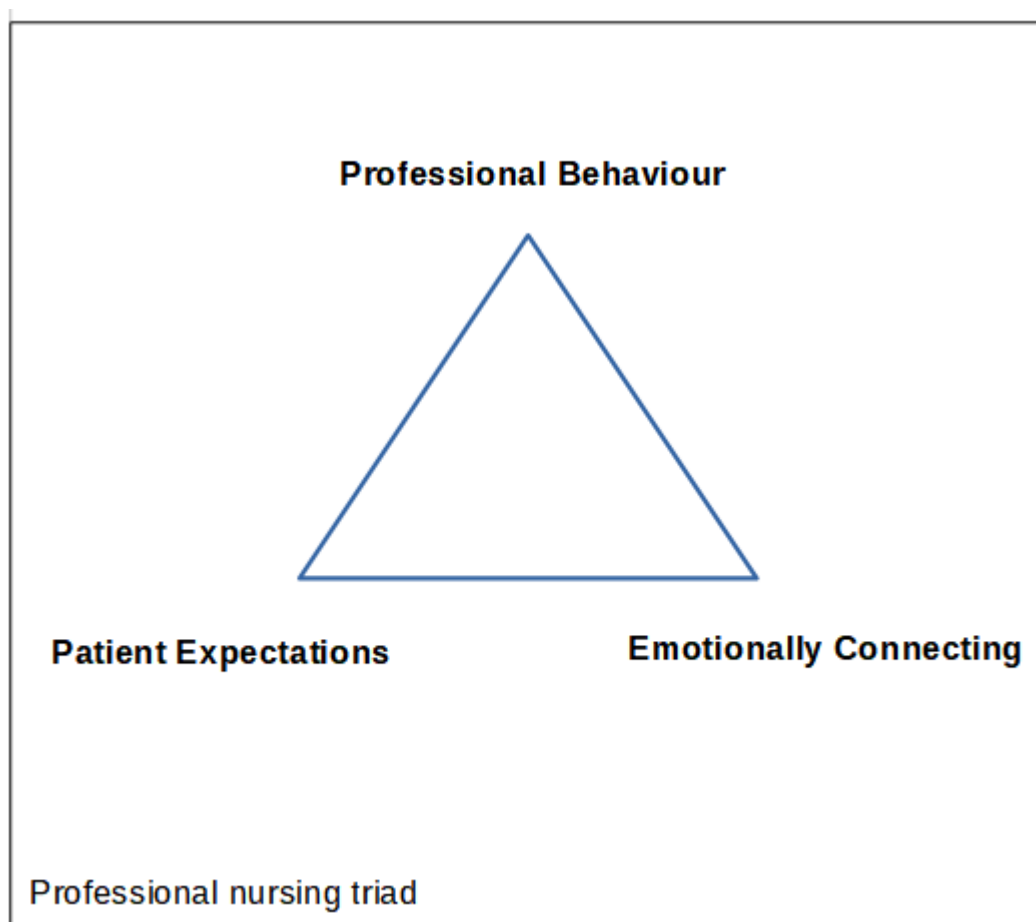


Figure 6-3- Students' Professional Nursing behaviour Triad

Professional behaviours refer to the way that nurses adopt a professional attitude that strictly adheres to professional regulatory guidelines. When discussing this type of behaviour, students frequently referenced the NMC code, and the requirement to follow rules rigidly. When adopting this pattern of behaviour, students described ways in which they could use their status as a barrier between themselves and their patients. However, behaviours in this repertoire, were usually thought to de-emphasise patient *expectations* and *emotionally connecting*.

Meeting patient's expectations described behaviours that were signified by a high degree of flexibility and person-centredness; putting the patient first above all else. Students made certain assumptions about the role that patients expected nurses to fulfil. These expectations might be that the nurse exhibits a high degree of professionalism and distance or conversely, that nurses should exhibit a high degree of humanity, care and compassion.

“patients don't always want someone to hold their hand though, sometimes they just want someone who knows what they are doing...and do things properly” (KU10-2 3rd year student)

Patient's expectations are therefore associated with one or two of the other behaviours. *Emotionally connecting* defines a set of behaviours that are strongly orientated towards building and maintaining nurse-patient relationships. These relationships are emotionally intense and associated with emphasising interpersonal connections and intersubjectivity. When students described the behaviours of positive role models observed in practice, they did not identify examples that included all three of these behavioural repertoires simultaneously. Instead, emphasis

was always placed on one or two corners of this Triad. Furthermore, examples were frequently given that explained how emphasis on one of these behavioural repertoires required compromise in the other two. Performance of all three behavioural repertoires simultaneously was viewed as idealistic and unworkable in practice. By learning to manage these different patterns of behaviour circumstantially, students believed that they were able to protect themselves from the risk of emotional stress. Withdrawing to a repertoire of professional behaviour (that they associated with efficiency, competence and duty of care) some distance between the nurse and the patient is established. This space provides a buffer against over attachment and emotional stress. Alternatively, at times when students perceived that the patient's emotional requirements were not being met- due to an emphasis on rigid and inflexible practices- students would actively engage with, and advocate for, the patient. Despite the NMC code making reference to individualisation, person centred care and advocacy, these aspects of professional regulation were often overlooked; choosing instead to emphasise the parts of the NMC code that require clinical competence, evidence-based practice and professional boundaries. It is these professional boundaries that provide an axis around which students adopted certain behaviours; blurring boundaries to get closer to the patient or maintaining boundaries to establish a protective distance.

6.2.3 Acting like a professional

The students discussed the length to which they would present themselves as being part of the professional nursing group. Acting like a professional includes their visible performance such as body language, looking like a professional, using appropriate language and appearing calm. These affectations were intended to promote a positive image to the patients under their care, and to the registered members of the nursing team. By appearing professional to patients, students emphasised the effect that this had in gaining patient's trust and in inducing compliance by the patients. Students realised that patients had a heightened awareness of whether their patients could trust them in the same way as they might trust a qualified nurse. This required the students to mask any feelings of anxiety or "panic" when undertaking tasks in which they lacked confidence. Students were aware that that showing signs of uncertainty in performing procedures might negatively affect the patient's ability to trust the student; trust being perceived as a prerequisite for patient consent.

"You've got to look professional, you have to always be calm. Patients want to look at you and trust you, no matter what you're doing, even though sometimes you might be panicking in your head. You want them to think 'okay, you can do whatever you want, I don't mind, I'll let you take my blood because I'm getting the right vibes from you'. So, it's about how you move, how you talk and even how you look into their eyes. I think sometimes we forget that the extra things like communication and gesturing and body language says so much, and people can easily pick it up." (KU2-1 2nd year student)

Acting professionally was associated with non-verbal and verbal communication skills. Using appropriate language for different situations gave students the opportunity to appear confident in their abilities to use medical terminology when talking to other nurses and healthcare professionals. However, being able to interpret medicalised language into lay-terms when talking to patients, allowed students to have the confidence to answer patients' questions about their conditions; reducing their dependence on the nurses supervising them to intervene. Students describe this need to 'fit in' with other nurses so that they could appear to be an established part of the professional group.

Students described the need to 'look the part' through body language and, where relevant, the nurse's uniform. Mental health students, who do not wear a uniform, noted how they had to present themselves as part of the professional group but without appearing like an authority figure; which might unsettle some of their patients, resulting in a loss of trust. These students identified professionalism as knowing when- and when not- to appear formal or authoritative. These students also recognised that the absence of a uniform required them to use non-verbal cues to a greater extent to communicate their professionalism.

Emulating the professional behaviours of registered nurses in their clinical placements provided students with a feeling of fitting in. However, even in the first year, students were able to identify behaviours that they recognised as either being professional or un-professional; choosing to emulate those behaviours that concurred with their existing ideas about professional nursing. The patient's experience of the

nursing care provided a frame of reference for students to evaluate the quality of nurse's work. However, students expressed some caution about conceding to some of these expectations. Despite the importance placed upon fulfilling patient's expectations of their nursing care, it was recognised that some of these expectations might be somewhat unrealistic. Students expressed the difficulty that they sometimes experienced when trying to balance patient's expectations with their requirement to attend to all other aspects of their work. Terms such as "empowerment" and "patient choice" were frequently used to describe the philosophy behind the nurses' approach to their work. However, it was clear that students felt that nurses needed to regulate the degree to which patients were able to define the terms by which care was delivered.

"some [patients] do have sympathy with nurses because they know we are quite pushed and it's not an easy job, but then, when they are in the hospital it's difficult... I suppose you've got to think about it from the patient's point of view and what they would expect from a nurse... but sometimes it's really hard to do everything that they want because you can give your all, but then you still don't have enough time for everything you want to do. So, sometimes you just have to say 'No' "(FG10-1 3rd year student)

As the nurse's role sometimes requires more time away from the bedside, and out of the patient's view, students were concerned that this might be interpreted by patients as nurses not caring about their patients. The professional responsibility for nurses to complete substantial documentation on a daily basis, was often cited as one such reason for which nurses might be out of the patient's sight. Concern was expressed

that the patients might perceive students to lack professionalism because of this absence. Therefore, students had to find a balance between appearing professional to their patient's (by being present) and appearing professional to the other nurses (by accurately documenting the care given). This was sometimes achieved by deliberately positioning themselves at a distance, but in sight of the patient.

Hiding their true feelings from patients at times when they felt stressed or anxious was described as a process by which students attempted to maintain a professional image. Being able to move between patients without transferring emotions from one encounter to the next was commonly cited as an essential part of appearing professional. Despite this being contrary to their desire to not appear as emotionally detached, students perceived this emotional management to be a quality that good professional nurses possess, and a behaviour that they should also adopt. Some students likened this behaviour to that of providing customer service, that might be found in retail occupations or other customer-facing work. Putting on a fake smile or feigning friendliness were thought to be disingenuous and inconsistent with nursing; revealing a lack of authenticity. However, restricting emotional reactions to distressing situations for the benefit of patients is a process that students learned through repeated exposure to challenging situations in practice. First year students' descriptions of this emotional management were indicative of providing customer service; emphasising the importance of hiding true feelings and feigning positive emotions. At the end of the programme, students described more autonomy in the way that they were able to manage their emotions, and yet still retain the image of being authentically caring, compassionate and empathic.

*“After the patient had died and we finished sorting everything out, I was still really upset about what happened. With everything going on I hadn’t had a chance to go and see the other patients in the bay, so I went in and started doing the obs[ervations], and the man in the next bed took my hand and said “are you alright love?”, and I wasn’t, I was in bits! And I started crying. I quickly had to pull myself together and carried on taking his [blood pressure] then I said to him ‘how about **you**? Are **you** all right?’ Because this is my job and I have to carry on regardless, but he didn’t choose to be in that room while [a cardiac] arrest was going on, it must’ve been horrible for him” (KU8-3)*

Separating personal and professional life provided some inconsistent discussions. about the extent to which people who know the students socially perceive them to be a nurse, and how patients who know the students professionally see them as a person. As noted elsewhere in this chapter, the boundaries between the social self and the professional self, became blurred as students tried to balance work and home life, whilst also presenting themselves as an authentic and genuinely caring nurse. The students view of nursing as being a lifestyle, or a way of being are therefore sometimes counteracted by the students need to present themselves as a professional.

6.2.4 Personal transformation

The journey from lay-person to professional nurse was revealed through students' narratives of their experiences during the undergraduate programme. In the interviews with final year students, a question was asked whether they felt that they had changed throughout the three years. Initially, students would claim that they had not changed personally; other than their acquisition of a substantial body of knowledge. However, students subsequently gave numerous examples of how they had dealt with situations in ways that were unrecognisable to themselves prior to the course. The reflective process of providing narratives about their experiences as students, quickly revealed to them that they had indeed undergone personal transformation. These transformations were a result of having experienced situations that they were unlikely to have encountered in other occupations (or on another degree course). Students found it hard to articulate exactly what had facilitated these transformations. Indeed, until they engaged in this reflective process, they had been largely unaware of them. Becoming a professional was therefore concluded to be a tacit process in which they learnt how to manage complex and multifaceted scenarios that were, at times, emotionally intense. Furthermore, they had developed processes that allowed them to gain the respect of professional colleagues and patients. They had become more self-aware about the limitations of their personal qualities, values and perceptions of the nursing profession and, as a result had defined new interpretations about the nursing profession. They had rejected some of their preconceptions about the nursing profession and internalised new understandings about the nurse's professional role. Whilst they all retained a passion for nursing, they had identified numerous ways in which nursing had failed to meet their

expectations. Final year students recalled having an idealised view of nursing in the first year; before having experienced the realities of nursing practice. Students had anticipated a smoother transition into the profession than the journey that they had actually experienced. From the outset, students had hoped that the personal attributes that they possessed prior to enrolment would be sufficient to practice and that the course would only provide the necessary knowledge and skills to become a competent practitioner. Students described their surprise at discovering that, in addition to acquiring new knowledge, they would also have to substantially adapt their behaviours when facing situations in which their usual behaviours would be inadequate to deal with the unexpected. This created a cognitive dissonance that forced the students to re-evaluate the adequacy of their innate abilities.

“It was my first placement, there was this man who seemed a bit quiet and withdrawn. And I love to talk to people, I’m always talking to strangers on the bus or when I’m out and about, it’s just one of the things I do. I’m a bit chatty. So, I thought I would go over and start talking to him, because he seemed a bit down. And I bounced over to him, all bubbly and happy and introduced myself, then he started having a go at me, he was ranting about not getting any sleep, constantly being disturbed, and having to wait for doctors... He was really cross! And I didn’t know what to say because normally people start chatting back if you act all bubbly. I didn’t really know how to respond, I sort of panicked... and I couldn’t just walk away. So that kind of made me think that maybe I need to tone it down a bit and work on my communication with patients. Especially angry ones!” (KI2-1 2nd year student)

Students recognised the need to adopt certain professional behaviours that differed from their usual ways of acting. Whilst some students were able to isolate specific incidents (such as the example above), others were uncertain about how, or when these changes had occurred. Even where specific examples could be articulated, students still recognised a whole range of behavioural change that they noticed in themselves that they could not account for. This implies that much of the personal transformation occurs as a passive and tacit process by which professional behaviours are internalised.

Students sought to identify specific roles within the profession that they believed their individual qualities would be well-suited to. At the outset of the programme, students had little imagination about nursing beyond the three-year programme but as they progressed through the three years, students recognised how their personal strengths might be used to develop a career beyond registration. Over the three years they had gone from wanting to be a nurse to wanting to use their nursing qualification for a specific purpose. Many students identified continuing education as a priority so that they might be better placed to address some of the deficiencies that they perceived in the current healthcare system. Some students anticipated a career as a specialist practitioner, others desired role in generating and disseminating knowledge through research and teaching.

“It’s crazy because when I came here all I thought about was being a nurse on a ward, I thought that’s all there was to it. I’ve never been particularly academic and some of this course has been really tough for me but I’ve actually got to quite like writing essays (laughs)... I know, who’d of thought it?! So, I definitely

want to do my masters now, if I'm going get a decent job in nursing and start making things better, I've got to have that masters!" (KU8-1 3rd year student)

Recognition that the nurse's role was far more extensive, and open to wider career possibilities, came as a surprise to many students. Their view of the role of the nursing profession had changed considerably once they had become exposed to nurses undertaking other roles (clinical nurse specialists, research nurses, GP practice managers etc). Some students even described the surprise that they felt when learning that their lecturers were also registered nurses. This limited view of nursing as a career gave some students hope when they were feeling unsatisfied by the roles that they were undertaking in their clinical placements. For example, many students stated that they had no intention of working in a hospital environment following qualification as they had discovered other nursing roles that were better suited to them. Some students even questioned whether they would have remained on the programme if they had not become aware of these alternatives. This finding is reinforced by statements made by students at the beginning of the programme who described nurses, and the nursing role, in terms that refer exclusively to working on a hospital ward. On the whole, students' personal transformations were often far more extensive than they believed them to be.

6.3 Overview of Microsocial processes

Students nurses possess a deep connection with the nursing profession. They associate nursing with a range of positive virtues that are demonstrated by a commitment to others. It is in their perception of themselves, as being in possession of these positive attributes, that gives them a sense of unity with the profession and creates in them a mental schema of how they expect the nursing profession to be. Students make comparisons between their own intrinsic ethical and moral virtues and those that they observe in professional nurses. Where these virtues are aligned, students interpret the observed behaviours as 'good practice'. Students base these interpretations on more generalised views of nursing that are correlated with vocation, duty, commitment and compassion. However, the origin of these views rarely comes from their own experience but arise from broader social ideas about nurses and the nursing profession that they internalise before entering their nurse education.

Being able to connect with other people on an emotional level is described as the essence of professional practice. Being an authentically caring person is a concept that students strongly associate with the profession despite them describing this quality as a ubiquitous human trait. Students attach their abstract concept of caring to more specific tasks as they progress through the undergraduate programme; developing new understandings of its relationship to their practice. As they begin to apply more concise definitions to the abstract concept of caring, students develop new ways to articulate the uniqueness of the nurse's professional role. The intrinsic qualities and values that they possess at the beginning of the programme are

maintained throughout their nurse education, despite the challenges that come from organisational, and local working practices. Students remain committed to the affective dimensions of nursing as these are representative of their own self-concept; they use their own self-concept as a reference against which other nurses are evaluated. The origin of their beliefs- that they are the ‘right kind of person’ to be a nurse- arise from a generalised perception of nursing being identified as morally virtuous, and a worthwhile vocation, that is derived from wider sources.

The overlap between self-concept and professional identity is greatest at the beginning of the programme but is reduced as practice experience is accumulated. This overlap is interpreted by students as defining nursing as a lifestyle; represented by a notion of blurred boundaries between work and personal life. Despite having internalised professional behaviours that allow students to extend these behaviours into their lives outside of work, over time, students are able to manage this duality of social-self and professional-self (Figure 6-4).

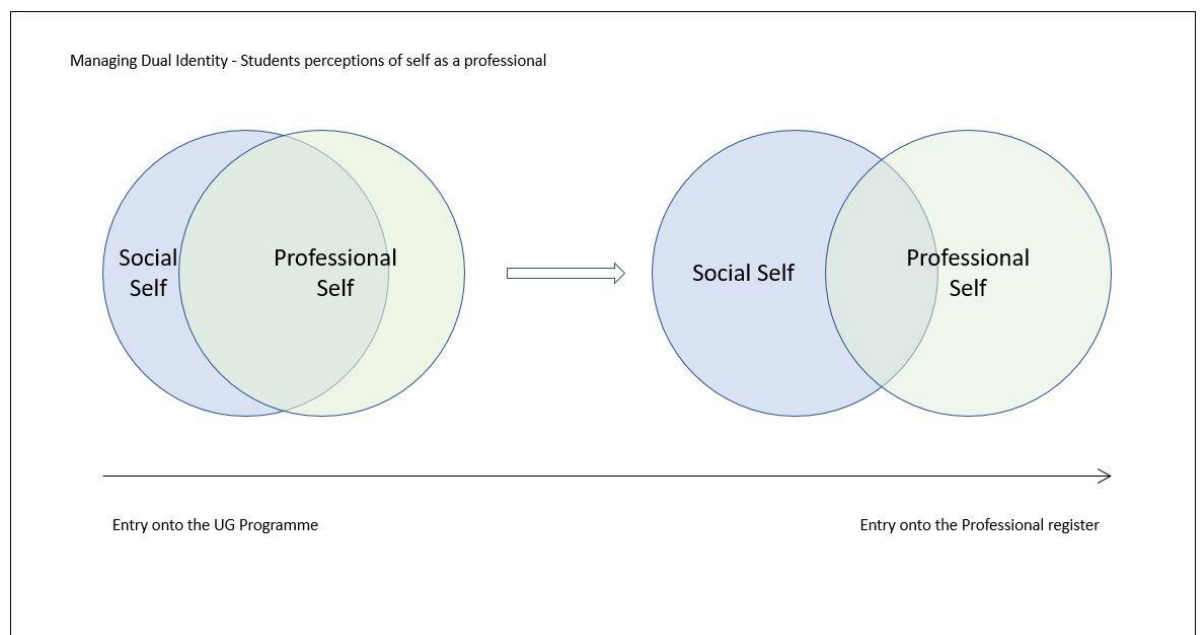


Figure 6-4 - The changing relationship between Social and Professional Self

This distinction of Social and Professional self does not affect the student's commitment to the profession but instead demonstrates more sophisticated processes by which students learn to protect themselves from being potentially harmed by emotional stress and burnout. The affective aspects of being a professional nurse- that students consider to be intrinsic to their personality- remain constant. Whereas other professional behaviours can be managed autonomously as required.

Family, friends and other people in students' immediate social world share their positive and negative perceptions of the nursing profession. Whilst these perceptions clearly had no impact on these particular students, it was discovered that students often feel compelled to defend the nursing profession when they encounter negative views of nurses and nursing. Furthermore, the processes, by which this defence takes place, use moral virtue as a rationale for entering a profession which is sometimes perceived as having a relatively low status. The tasks undertaken by nurses that are viewed as unpleasant or demeaning are re-contextualised by students by using language that refer to them as therapeutic interventions; specific tasks are described as being necessary for achieving the higher purpose of helping those that are unable to help themselves. Furthermore, students frequently feel compelled to inform others about the full extent of nursing's professional role, particularly when they feel that the role has been misunderstood.

The moral foundation of the profession is used to defend the nursing degree against criticisms that imply a lower status to other degrees. Students refer to their own sense of moral purpose when justifying a career in nursing over others that might

bring higher financial rewards, social status, or are not associated with shift work, physical and emotional stress and unpleasant tasks. When making the decision to enter the nursing profession, the reaction received from those people who know them, well focuses on the type of person that they are, and the compatibility between their personality type with that which is perceived to be required for the profession. These evaluations are based on broad perceptions about what a nurse should be like as a person, and reveal a more widely held view of nursing's professional identity. Students are primarily motivated to become a nurse due to its moral purpose, value to society, and its potential to provide a high level of job satisfaction. More specifically, the willingness to develop strong interpersonal relationships with patients, and the expectation of making a positive difference to patients' lives, are primary motivations for undertaking a career in nursing.

Nurses relationships with their patients are strongly associated with the quality of nursing care given. Maximising the use of patient contact time allows the nurse to attend to both physical and emotional needs. The emotional connection between nurses and patients is an essential and unique function of nursing that these students value. Furthermore, this particular contribution to healthcare is viewed as essential to the humanisation of medical treatment. By knowing the patient, understanding their individual requirements, and advocating for them, students define the nurse's role as an interface between patients and a healthcare system that often de-individualises them. Personal motivations to join the nursing profession highlight the student's moral orientation towards people rather than disease.

The methods by which nurses make positive contributions to individual lives are transformed throughout the programme. At the beginning of the programme, students are primarily motivated by their interactions with individuals and the desire to change lives through direct patient contact. As the programme progresses, this perception of the nursing profession's role is reconstructed, and orientated towards leadership and management. Witnessing poor practice and becoming aware of negative images of nursing care motivates students to consider ways in which nursing can transform people's lives, by facilitating changes to the way that care is delivered. Recognising the need for strategic change through leadership and management forces students to evaluate their own personal goals following qualification. This transformation highlights how student's perceptions of the nursing profession's identity are influenced by microsocial processes during the undergraduate programme.

The nature of the relationships that nurses should have with their patients are already known to the students prior to commencing nurse education. Influences from friends, families and from their own personal experience, shape and image of the ways in which nurses interact with patients under their care. Students define these relationships as a form of authenticity that breaks down the barriers between them. The professional distance between nurse and patient is described as being considerably smaller than that of other healthcare professions. By managing behaviour in this way, the student is able to adopt a professional image (viewed as being bound to rules and regulations) with that of a caring and concerned fellow human. Humanising medical treatment and offering flexibility through patient participation, are hallmarks of the student's perception of nursing's professional

identity. However, by increasing the professional space between nurse and patient by limiting interaction, or retreating to less a flexible approach to care, demonstrates ways that students learn to manage the intensity of patient interaction as required. The motives for limiting interaction with patients define limits of good and bad practice. Limiting the nurse-patient interaction might be necessary when workload is high, and an even distribution of constrained nursing resource is required. This is still recognised as good nursing practice but is felt to be somewhat compromised; students understand the necessity to adapt to workload pressures in this way but describe that this creates a disconnect between *what should be done*, and *what can be done*. The deliberate limitation of patient interaction for reasons other than high workload are viewed as being a result of poor leadership, negative nursing culture and lack of care and compassion amongst those nurses. These areas create the highest level of anxiety in students due to the dissonance with their own perceptions of what nursing should be like. However, repeated experience and knowledge acquisition empowers students to manage their behaviour in ways that are a truer reflection of the way that they believe that nurses should act.

The personal transformation that students experience throughout the three years of the undergraduate programme is a tacit process of internalising subtle new ways of utilising their own personal qualities in a professional context. The reflective process that occurred during the interviews and focus groups facilitated the students' awareness of the extent to which they had been transformed by their clinical and academic learning. Students develop new meanings about the nursing profession as they move through the series of clinical placements. Experiencing both good and bad nursing practice both have a profound effect upon their future direction as a nurse.

Where deficiencies are encountered in the quality of nursing care, students identify ways that they might be able to challenge and change these practices. Furthermore, where positive examples of nursing care are experienced, students receive validation of their deeply held beliefs about what the nursing profession should be. As students become aware of the variety of roles and means by which nurses are able to effect change, they establish a new target professional identity for themselves, and a vision for how they hope nursing to be in the future.

7 Analysis of Mesosocial Processes

The influences in the formation of professional identity, that exist between those of the individual's perception of self and of the broader macro social influences, will be discussed here. These Mesosocial level processes create an interconnecting network of influences and processes that exist between the individual and their social world. The participants discussed themselves in relation to the profession by describing certain social practices and experiences that occurred throughout the programme. These influences were broadly divided into the two major components of the programme: the university's requirements for completing the undergraduate degree, and the NMC's requirement of clinical competency for entry onto the professional register. Despite the integration of academic achievement with the development of clinical competence in the programme's curriculum, students referred to these as distinct and mutually exclusive. The most common terms used to differentiate these were: 'in uni[versity]' to describe their academic/theoretical learning and, 'in placement/practice' to describe their learning through practice experiences.

The data were further organised into three broad categories to reflect the student's perceptions of their development of professional identity throughout the programme:

- 1) *Acquiring professional knowledge*- the knowledge required for nursing
- 2) *Connecting with the 'real world' of practice*- gaining experience in practice
- 3) *Identifying role-models*- orientating themselves towards their professional goals

The gerunds '*Acquiring*', '*Connecting*' and '*Identifying*' suited the student narratives and were chosen because they most closely reflected the way that students described

these processes. Students saw professional knowledge as being something that was *acquired* through lectures and seminars in the university. Most often, this knowledge was described as purely theoretical, abstract, and distinct from learning that took place ‘in practice’. The students described their attempts to *connect* what was learned in university when they were in their practice placements, but often found the these to be incompatible. Commonly, the clinical practice environment was referred to in terms of it being the ‘real world’, whereas, the learning gained from the university was described in more pejorative terms such as “theoretical stuff” and “the ‘airy fairy’ bit”. Students talked about the process of *identifying* those nurses who represented exemplars of how the conflict- between knowledge and practice- could be reconciled.

Within these categories, the coded data revealed processes that demonstrate the way that the students internalised their understanding of the professional world and negotiated their ideas about what it means to be a professional nurse. As the programme progressed, the accumulation of the student’s experience led to new interpretations of professional nursing. These experiences were encountered in the University and during their clinical practice placements. Moreover, their existing perceptions of the profession were frequently challenged, and required them to consider new ideas about the reality of being a nurse. Table 7-1 shows how the data revealed the role of the university and the clinical practice placement in shaping their understanding of the profession’s identity.

	General themes	Categories	Description
Mesosocial Processes	Acquiring professional knowledge (section 7.1)	Being an academic/part of an academic profession (section 7.1.1)	Reconciling the requirements of an academic programme with the perception of nursing as being a practice-based occupation.
		Being part of a 'new generation' of nurses (section 7.1.2)	Internalising the belief that the students are expected to rectify past failings in the profession.
		Evaluating the value of the nursing degree (in section 7.1.1)	Comparing the status and value of nursing undergraduate degree with other professions.
	Connecting with the 'real world' of practice (section 7.2)	Having 'baseline' knowledge (section 7.2.1)	Identifying the limits of which knowledge gained in university can be applied in practice.
		Learning what <i>not</i> to do (section 7.2.2)	Prioritising the learning of how the nurse should not behave, rather than how they should.
	Identifying role-models (section 7.2.3)	Modelling desirable practice (in section 7.2.3)	Identifying exemplars of practice that mirrors the target identity of the student

Table 7-1- Meso social processes

7.1 Acquiring professional knowledge

The knowledge required for professional nursing practice was discussed by the students in three distinct ways. The first of these types of professional knowledge related to the practical skills that were required to perform nursing tasks, such as providing physical care, administering medications, documenting patients' progress etc. This learning largely took place in clinical practice placements, with some additional 'skills sessions' held in the universities' Skills Laboratory. The second type of professional knowledge was the more abstract, theoretical elements of professional practice, for example, ethics, nursing theory, legal and professional regulations. These were delivered in lectures, seminars and through an electronic learning system. Thirdly, a type of knowledge that was often referred to as 'science' was described; this knowledge was centred on the biomedical sciences, such as anatomy, physiology and pharmacology. Again, these were delivered through lectures and classes in the university. The role that these three types of learning had in their professional development, appeared to indicate their individual perceptions of what a nurse needs to know in order to practice. Furthermore, students evaluated the importance that was placed on each type of learning and this reflected their individual preference and learning style. Finally, the influence that of each of these types of learning had on the individual student appeared to highlight their personal and professional goals and served as descriptions of their target identity as a professional nurse. This target identity therefore informed their engagement with the learning experiences that they were offered during the programme.

7.1.1 Being academic/part of an academic profession

Students described how the acquisition of an undergraduate degree seemed to indicate that they were not only becoming academics but were joining a profession that was becoming more academic than it had been before. At the time of the first focus groups (September 2012), the decision had recently been made by the NMC to mandate that all professional nurses are educated to graduate level upon entry to the register. The students recognised this transformation as being a significant shift from the way that nurses had been previously educated. Therefore, for the three years of the programme, they would have to undertake a period of academic study in a higher education institution (HEI). In addition to this, students were placed in clinical environments to gain experience and to develop their clinical practice; this being part of the requirement to enter onto the professional register with the Nursing and Midwifery Council (NMC). Whilst the latter has, historically, always been essential to nurse education, the former was considered to be a new development, despite nursing degrees having been available in the UK since the 1960's.

Attending university and undertaking studies away from the clinical environment were generally described as the 'academic' part of the programme. Furthermore, there was a perception that the profession had now become more academic as a result. The students had differing opinions on this issue and generally described this in terms of *being an academic* and *being part of an academic profession*. Some students questioned the necessity for the academic requirements in a profession that they considered to be primarily practical in nature:

The academic stuff is important I suppose but sometimes it just feels like it's just taking up valuable time that could be spent out in practice, you know? Because it is out there [in clinical placement] where you do the real learning...actually learning how to be a nurse. I am not sure how much the degree actually helps you do a lot of the day-to-day stuff if I'm honest (FG10-2 3rd year student)

The notion that 'real learning' is that which enables students to attend to the physical aspects of care was often declared as a priority over the other forms of learning. The reason for this emphasis on practice learning appeared to be that knowledge acquisition needed to be visible to patients and other nurses. This outward presentation of competent professional practice draws a parallel with the microsocial process of *Acting like a professional* (see section 6.2.3), in which the student recognises the importance of demonstrating professional competence as a means of gaining the trust of the patients and 'fitting in' with the other nurses in the team.

"Well, nursing is mostly about the practical skills of looking after someone. You can't really learn all of that in lectures or books; you have to get out there and do it. I'm not saying that all of the academic stuff is pointless, some of it is really interesting, but when you are out in placement, you are going to be judged on how well you do things not on what you know" (FG5-5 2nd year student)

By arbitrarily categorising their learning into practice or theory, students placed different values on the perceived importance of each. Furthermore, learning practical skills was not described as being acquired in the same way as learning the theory that underpins practice; 'academic' learning was achieved by books and lectures,

whereas practical skills could only be learned in practice placements. However, the students did recognise that there was a growing need for degree educated nurses. They described how an increasing demand for the *academic side* of the profession was a necessary response to the changing role of the nurse. The students referred to the new roles and responsibilities of the nurse as being a catalyst for the transformation in nurse education. Furthermore, they regarded themselves as a part of a changing landscape in education and practice:

“The academic side has obviously changed quite a lot because... when was it? Before 2000, was it? yeah, Project 2000, you didn't need a degree, or it wasn't a degree educated profession and now of course they are changing it so you have to be degree educated, so there's going to be a big change I think, more educated people get in. I suppose with the more responsibilities you have, the more training you need” (FG3-1 2nd year student)

Students clearly identified how changes to healthcare, and the evolving role of the nurse, required modern nurses to know more than their predecessors. It was recognised that there was more to being a nurse than just the practical tasks that are associated with the role. However, it was evident that they did not believe that this was widely understood by those outside of the profession.

“But what everyone's got to accept- who knows about nursing- is that the demands are academic now... its part of the role that you do have to have an academic ability to take on board what's expected these days.” (FG2-2 1st year student)

Much of this explanation about the changing role of the nurse, and the requirements for higher levels of education to become registered, arose from their reactions to the

criticism that nursing faced in response to the recent change to an all-graduate entry to the profession. Students defended this change by describing aspects of the nurse's role that did not exist in the past. Frequent reference to how nurse education was previously based on an apprenticeship style of training was made. This was considered to be an outdated method of educating nurses in the context of the contemporary nursing role. One of the key functions of modern nursing, that was used to differentiate it from the past role, was a collective term 'paperwork'. Paperwork was used as collective noun for a range of administrative activities that nurses must undertake during their working day; although they did not specify what this paperwork actually entailed. Nevertheless, this aspect of the nurse's role was used to legitimise the requirement for nurses to possess a degree prior to registration.

"This debate about whether you should make nurses go to university or not...I think you should. Not a lot of people, maybe not a lot of people agree with me, I don't know, but because the role has changed. Before, maybe you could learn everything on the job, whereas now because of the paperwork, what they expect from you is different, and I don't think you can learn that, like the drug knowledge and everything, you can't learn everything on a ward. (FG4-2 2nd year student)

The need to have a degree to meet the responsibilities of modern nursing practice was frequently cited due to the profession's expanding role. The comparison between current and previous nursing roles and responsibilities were often highlighted as a positive motivation to undertake a higher level of preregistration education. Being 'more educated' and 'academic' describes how these students saw

themselves as part of a progressive change to improve professional standards, particularly among second and third-year students, who had accrued some personal experiences of working with practising nurses, who did not possess a degree qualification. Some students expressed a resistance to the requirement to undertake a degree to enter the profession. Those students who felt that they were not academic by nature, placed a higher value on possessing the 'core values' or on personal characteristics, than on the theoretical knowledge taught on the programme.

"I have had to literally drag myself through the academics of the course because this is what I want to do. So, I can see where [the NMC] are coming from because there may be a variety of people that are more academic than less who are good at the nursing skills. But I still think that you get a lot of those people who really want to be a nurse, for the core values of nursing that push themselves to do the degree because they know that that's the only way that they can go." (FG11-3 3rd year student)

Students at the beginning of the programme frequently viewed the move towards nursing becoming an all-graduate profession as a new innovation that was introduced in response to failing care standards. These students also demonstrated a lack of knowledge about how nurses were prepared for registration in the past. Their observations implied that the lack of education of those nurses might be responsible for some of the current failings in practice standards. For example, the prevention of medication errors through the ability to competently perform basic drug calculations was perceived to be an aspect of nursing that was absent in non-graduate curricula,

despite drug calculation having been an essential requirement for registration for many years beforehand.

“Before it was like, you go to hospital and do the training, it wasn't like academic, it was more practical and less theory, and now it's like, you have to do certain...you have to do maths tests, you have to pass the English [test], which is important because there's been a lot of problems with medication errors you know? Problems with people not being able to measure out medication the correct way and give the right patient the right medication, and so on. So, there's a lot of problems like that, so I think that academic side of it, which has now come into it is important, in that it helps nurses to become more competent.” (FG1-6 1st year student)

Professional autonomy and accountability were frequently cited as the rationale for nurses to possess a degree. The increasing distinction between nursing and the medical profession, with regards to clinical decision-making and nurse's accountability for their own actions, reinforced student's perceptions of nursing as becoming independent from its medical counterpart.

“I think that there's a lot of things that nurses do in their job that does require quite a high level of academic ability, if you're calculating on your own, the doctor just writes it, signs it and then we're expected to check that and make sure that that's right as well and we are supposed to take the rap when they've done it wrong. They've written it wrong but the buck stops with you. So, if you don't have the degree...you don't have that ability to do the calculation where you're potentially giving someone a lethal dose of

medication. So, I wouldn't want to be looked after by somebody that doesn't have [a degree].” (FG1-3 1st year student)

The need to possess a degree in order to practice competently was a recurring theme throughout the study. Whilst most students viewed the move positively and saw it as an opportunity for the profession to improve the quality of patient care, others questioned the necessity to possess a degree in order to become what they described as a ‘good nurse’. In the following extract, the student actively separates the possession of academic ability with those that have the “core values” of nursing and suggests that the two might be mutually exclusive.

“Some people are academic and can do all of the theory stuff without much trouble but it doesn't mean that they will be a good nurse. Others have more of the core values and the right personality for nursing. They are not so academic but are good nurses anyway. I don't think that you have to have a degree to be a good nurse, just those values. If you have them then the rest will just come anyway, I think.” (FG11-4 3rd year student).

The idea that completing the degree part of the programme as a professional requirement for practice (but not necessarily essential to become a good nurse) opens up a discussion about how the degree program itself influences the students' understanding of what is important when learning to become a professional nurse. Seeing the degree as a merely a mandatory requirement-but of questionable value in comparison to learning practical skills- was echoed by some other students. Those students often cited their own strengths with regards to education, practical skill and personal values as factors when evaluating nursing as an academic discipline:

“I wouldn’t consider myself to be particularly academic...I find writing essays and doing all the reading quite difficult actually; I learn best by seeing and doing things, I am more of a practical person. But, because being a nurse is what I really want to do and I just want to look after people, I am prepared to put myself through all the academic bits to get there.” (FG1-5 1st year student)

Feeling compelled to do a degree course in order to become a nurse was highlighted by some students. Despite their lack of commitment to the idea that nurses should be degree educated, this did not appear to diminish their commitment to becoming a nurse and they did not seem to be deterred by this requirement.

“If you didn’t have to do the degree to be a nurse, I would still do it. I don’t think that it is the most important thing...you have to be the right kind of person to want to be a nurse in the first place. But I think that if you want it badly enough then you will just push on through. So, I suppose it’s about attitude not how clever you are. I know other people disagree though.”
(FG9-3 2nd year student)

Inevitably, due to the exclusive selection of student nurses enrolled on an undergraduate programme, this study did not include participants that had decided against a career in nursing due to the academic requirements for entry. However, there was some variation in how valuable the degree is to professional practice. Some students were even attracted to the profession because of the academic component to the programme.

“I am a bit of a geek (laughs), I love learning and reading and doing all the science and academic stuff. But I don’t think that stops me from being caring and compassionate. Actually, I think that nursing is the best of both worlds! You have to be clever AND caring. I guess that some are more one than the other...it is down to the individual I suppose, but nursing lets you play to your strengths. Some nurses I have seen are really smart, and I mean REALLY smart; they know so much! Then there are others who are...well, they are not stupid but they maybe aren’t so knowledgeable, but they are amazing nurses. They are so caring and just seem to know how to handle different situations. You can be both...I think maybe most are to some extent, but they all want to be nurses, they all care about the patients; they just maybe do it in slightly different ways?” (FG9-4 3rd year student)

Despite these mixed opinions about degree education, students perceived the profession to have moved away from its vocational origins and being a practice-based discipline, towards one that places a higher value on academic ability and theoretical knowledge. Despite some students feeling that the possession of a degree might be of lesser importance than possessing the personal attributes of being caring and compassionate, their opinions were unanimous when presented with the contention that degree educated nurses might lack the ability to be caring (See section 8.2.1.). Along with the students’ changing understanding about the role of the modern nurse came a renewed way of thinking about nurse education. The relationship between being part of a more academically orientated profession, and a need to improve care quality standards, came through strongly in their responses.

At the beginning of the programme, students struggled to anticipate how some parts of the curriculum might be relevant, or even necessary to become a nurse. Notably, communication skills and the delivery of compassionate care, raised questions about the connection between theory and practice. Students' perceived that, by being accepted on the programme in the first place, that they were already in possession of these skills, and therefore needed no further education about them. As students accumulated knowledge and practice experience, they began to recognise the relevance of this knowledge, that they had questioned as irrelevant beforehand.

"In the first year we did this communication module and I thought "oh my god! what a waste of time! I am coming here to communicate with people. Do they not know that we do that every part of the day?". And it's only when you complete that communication module that you actually realise how your eye-contact, how your verbal expression is, and how, you can come across, how you don't want it to come across. So, I actually think that the degree nurses will come across better because of it." (FG12-2 3rd year student)

Perceiving themselves as being the right person for the profession initially foreclosed the potential for learning how these intrinsic qualities could be developed into essential skills for practice. The relevance of classes about caring and compassion were treated with similar disregard. Rarely did students make strong associations between the theory and practice. Students at the beginning of the programme made some connections between theory and practice but generally treated them as separate entities. Towards the end of the programme, this gap had been reduced somewhat,

but students had become more discerning about what knowledge they personally felt that they needed to develop their own individual qualities.

7.1.2 Being part of a ‘new generation’ of nurses

From the early stages of the programme the students became aware that they were different from those nurses who were currently in practice. This difference was partly explained because they were subject to the new academic requirements for registration. They were also made aware of recent examples of poor practice- which had been described in public media- that drove the need for change in the profession. The students described how, from their very first day, it was emphasised to them that they would be taking on the role as ambassadors for the profession in the future.

“Do you remember that speech we had the other day? I can’t remember who it was, but she was saying that we are the nurses of the future, and that the profession is in our hands now, and when we have got our degrees then we have to change the world, or something like that. I was like Whoa! No pressure then!” (FG7-3 1st year student)

The students had clearly been told on many occasions that they were being viewed as part of a new generation of nurses who are essential to a larger project of transforming the profession into something better than it had been before. This was understood to be a means of improving standards of care, but also to be a response to the profession’s failings. So, rather than entering a profession where they were expected to conform to the prevailing behavioural norms, the students described how

they felt that they were expected to create a new, and better, profession, but without yet having the necessary experience and knowledge.

“They keep telling us in Uni that we have to change practice and we have to be change agents. It’s like we have to put right all of the things that have gone wrong in the past. Which is good I suppose because obviously we want things to get better...for patients to have better care and all that. But when I first heard that was right back at the beginning of the course and I didn’t know anything about nursing, and I thought “god, what is wrong with the profession if they want us to go and change it!”. You know, this was like our first week of the course!” (KI10-4 3rd year student)

Some of the need for this change was considered to be to move nursing away from its past and towards a more contemporary vision for the profession. In their responses, it was often stated that nursing is no longer a vocational subject, and that, having let go of its vocational roots, nursing was now an academic subject in its own right. Having ‘a vocation’ and ‘being academic’ were described as disparate entities. Furthermore, the idea of nursing becoming an academic subject seemed to have an important role in modernising the profession.

“I think just the progression of the education within [nursing] has shown that it’s moved forward a bit. And so, it’s completely different to how we study now, where it’s all now going to be made compulsory to be a degree isn’t it? And, I think, just that making it more of an academic subject, rather than a vocational subject has, kind of, put more of an importance on it.” (FG1-6 1st year student)

Students felt that it was important that those outside of the profession, no longer viewed nursing as a vocation. They wished for nursing's vocational image to be replaced by a more contemporary view of nursing as a forward-looking profession.

"I think it's important to get people to have a different understanding [of nursing], it's an evolving time I guess for the profession from how it started and where it's going and probably where it should go in the future. It never used to be a degree programme, it was more like a vocational thing" (FG3-3
2nd year student)

The challenge of being at the forefront of a change to the nursing profession clearly presented some potential resistance from the existing nurses. The recognition that they were about to be immersed in transforming the profession was viewed as a difficult task, and that new ways of thinking about the profession were needed.

"We're building on top of ruins constantly, it's like we're trying to build new on top of old, and I think it's going to be a hugely difficult task to actually, to move towards a less ritualistic, more, kind of, greater vision. I just think that it's going to take time, lots and lots of time and hopefully with the new... as there's new younger nurses coming through with a different... because we obviously think that what we are taught is right but maybe the older nurses think that this is wrong and that what they were taught was right." (FG5-1
3rd year student)

Traditional ways of thinking about nursing were considered to be inhibitory factors in the project of modernising the nursing profession. Students recognised that they

were being charged with the task of driving change in the future but were concerned that they would be met with resistance by those who were educated in the past.

"I think that's the only way forward is actually to phase out the old line of thinking, to actually introduce a little bit of more of [our] fresh minds and you know, new nurses. That's the only way that things are actually going to change. Because there's always going to be like "oh you know, in my days I was taught like this, and I was trained like that." (FG5-2 3rd year student)

A clear conflict was identified between the way that students perceived their target identity as a nurse and their need to 'fit in' with existing practice. Their future role as a nurse had been shaped by the University, who had informed them that they were to be responsible for the future of the nursing profession. This transformation of practice was perceived to be a result of failing standards of care that had been seen in the public media and from their lectures in university. Furthermore, these failings were commonly associated with outdated ideas about the role function of the nursing profession.

7.2 Connecting with the ‘real world’ of practice

The students drew clear distinctions between the two domains in which they developed their professional skills and knowledge; the University and their clinical placements. Rather than seeing the knowledge gained in these two domains as complimentary, they were frequently compared with one another for their relevance to what each might offer the students as they progressed towards professional registration. The learning that takes place in each of these domains was often described as conflicting with one another. University was associated with learning about what *should be done*, and their clinical placements were where they learned about what is *actually done*. Students often used the term “the real world” to describe how they experienced the practice of nursing, and frequently questioned the utility of the knowledge acquired in university that was intended to underpin that practice. However, they did not outrightly reject the theoretical knowledge required for practice, instead, they used this as a starting point for their professional development.

7.2.1 Having ‘baseline’ knowledge

The role of the University in acquiring professional knowledge was questioned more and more by the students as they progressed through the programme. At the early stages of the programme, much of what was learned in the University was considered to be valuable. However, through the latter stages of the programme, the importance of this knowledge began to be questioned. In some cases, it was challenged or even refuted completely. Students questioned the validity of what they were hearing from their lecturers as they considered that contemporary nursing practice might not be learned using outdated approaches to nurse education.

“We keep getting a lot of the lecturers saying "when I was training back in the 80's...", and it was just so, because you learnt on the ward and some days, I think, well I love the academic side but sometimes I think that would be really good to just get in there and do it! Just learn, you learn your craft by being there rather than trying to remember what you learned 2 months ago and then put it into practice in placement, and I love that idea.” (FG3-6 2nd year student)

Learning *in* practice and learning *about* practice in the classroom setting seemed to create a conflict for students. On one hand, they valued the academic status of nursing students under the current system and valued the importance of acquiring knowledge for practice. On the other, they placed a high level of importance on developing their professional knowledge by immersing themselves in the world of practice; a style of learning that they associated with the past. Students generally saw the benefit of nurses being degree educated, and considered this to be a necessary requirement for modern nursing practice. However, they were less than certain about

the role that 'academic' knowledge might have in the 'real world' of practice. The university and their clinical practice placements were viewed as different worlds, with different learning processes. In the university, they were presented with a view of the nursing profession that was often considered to be somewhat idealistic and anachronistic. In their practice placements, students were exposed to a more chaotic and uncertain world in which their theoretical learning might, or might not, be able to be applied. Students placed a high importance on clinical practice learning as this was considered to be that which would be most likely to enable them to function as a qualified nurse.

"I do still think that we should spend more time out on the wards than we actually do. Although I really value the time that we spend in university and the things that we're learning I do sometimes think "oh my god! we've only been out on the ward for x amount of weeks!" and by the time you qualified we are going to be expected to be able to have our own patients, have we spent long enough out in that setting?" (FG6-1 3rd year student)

Students frequently highlighted this desire to gain more practice experience on the undergraduate programme and none claimed the need to acquire more theoretical knowledge in university. The primacy of practice learning as a way of developing skills to deal with the challenges of the clinical environment was evident across the data. Whereas, the learning that took place in the university was seen as being more limited in its relevance to practice.

"All the stuff that we learn in uni, I think, is just like the baseline knowledge. You get taught about the type of nursing that maybe we should be doing but, in reality rarely gets done. When you go out into practice you realise that

nursing isn't really like that. Maybe it was once, I don't know, but it's very different to the nursing that I see in practice.” (KI10-2 3rd year student).

The university was often described as being responsible for presenting the students with an historical image of nursing that was somewhat idealistic and incompatible with their observations of practice. The image presented by the university was viewed as either a baseline (or a minimum expected standard) or as an unachievable expectation of exemplary nursing practice. The shock that some students experienced when on their first placement seemed to be more pronounced in those students who had limited experience of nursing prior to commencing their studies.

“Wow, what a shock I had on that placement! We'd had lectures for weeks about nursing and what we should be doing and what it would be like...it was nothing like that, it was crazy! I didn't know what to expect and I guess that maybe I was a bit naïve about nursing, but what we had been told and what we saw...so different!” (KU8-1 2nd year student)

Even those students who had some prior experience of working in a clinical environment beforehand, felt a disconnect between the image of nursing portrayed to them in the university and that which they saw in practice.

“I thought my experience as a carer would help me on that first placement because I had seen lots of stuff and I knew what wards can be like sometimes. And in Uni, we had been inspired a lot, about being professionals and having to learn all these new things. So, I was really excited about it, but it was so busy, the nurses were just run ragged and looked exhausted the whole time. It's not that they weren't caring but they just didn't have the time to do all

the nice stuff that we had been taught about in uni. I guess I thought that it would be different to that” (KU7-3 2nd year student)

The disparity between nursing, as described by the university lecturers and the ‘real world’ that students experienced appears to have exacerbated the perceived difference in importance between the knowledge that was acquired in university and the knowledge acquired from practice experience. In the early stages of the programme, inexperienced students relied on the university to provide them with the knowledge and understanding of nursing. As they progressed through the programme, it became evident that students shifted their emphasis towards the clinical placement as the source of their professional knowledge; with the university having a diminishing role in the development of professional practice. Students described the mixed signals that they received from the university.

“I get a bit confused between the old-fashioned style of nursing and the new ways of doing things. We had this lecture on the history of nursing. Don’t get me wrong, it was interesting...I learned a lot about the profession, but we were sitting there and thinking “how is this going to help us be better nurses?”. I think the past should be left in the past. We’ve got different problems to deal with nowadays!” (2nd year student KU 7-2)

Therefore, a conflict exists between students being endowed with the task to modernise the profession and being presented with a professional image of nursing that is viewed as outdated and irrelevant to contemporary practice.

7.2.2 Learning what not to do

Students provided some insights into the way in which the ‘ideals of nursing’ were presented to them throughout the programme. They perceived that, in the University, good nursing practice was exemplified by appropriate professional behaviours, such as maintaining confidentiality, individualising patient care and spending time with patients. However, students felt that, negative cases observed in practice, were more powerful motivations to learn about what they considered to be appropriate ways of practicing.

“I think that what I have learned most over the last 3 years is...how not to be a nurse rather than how to be a nurse, if that makes sense? Everything that I have picked up on I have found that there is a better way, or a newer way of doing it. In the beginning, I blindly followed whatever the nurses did without question. I trusted them because they were qualified and had the uniform so I just assumed that they would do the correct thing. Over the last couple of years I have come to realise that a lot of what they did was not necessarily right.” (3rd year student FG10-2)

The use of negative cases was frequently cited as the means by which good practice was reinforced. Frequent references to the consequences of bad practice, and negative public media accounts of the failings within the nursing profession, framed students’ learning about professional practice. The gap between good and bad practice created a space in which they attempted to reconcile idealised practice and professional negligence. Students described their observations of practice that did not match those that had been presented to them in university. As a result, students revealed the influence that educators and practicing nurses had on the development

of their professional practice. Their expectations, that practicing nurses would act and behave in ways that were consistent with what they had been taught in the university, were sometimes not realised:

“I learned a lot of things by myself, when we went onto placement for the first time I had no real idea about what we were supposed to be doing with the patients or how we were supposed to act. In Uni, they had told us all about acting professionally and how to do the basic stuff like taking blood pressures, but other than that we were on our own without a clue. I would watch the other nurses and just copy them because...well they are nurses and they know what they are doing, right?. But then we got taught all this stuff about nurses practicing badly and neglecting patients and stuff like that and I got really worried that I might be learning all the wrong things, you know?”

(FG9-1 2nd year student)

Students were initially unsure about what good nursing practice looked like, due to the ambiguity of what they were being taught. The only frame of reference that they felt able to use to identify good nursing practice, was to adhere to a generalised set of context-free rules; notably those that were laid out in the NMC Code.

“I don’t know, it’s like you get taught to follow the [NMC] code because if you don’t you get into trouble...but you don’t really get told what to do...just what you don’t do. As long as you don’t do any of the wrong things then you are supposed to be doing it right. It’s the wrong way around I think.” (FG10-

5 3rd year student)

The fear of discipline, by breaching professional regulations, provided a powerful motivation for students' learning. The risk to the students' future career by acting outside of the professional clearly gave them a broad delimitation to their behaviours in practice. However, they entered their first clinical placements with only generalised concepts upon which to base their practice. Aside for learning specific clinical skills (such as taking a blood pressure, moving and handling, and handwashing), students described having only a limited knowledge of what they should be doing. Therefore, they were dependent on learning how to apply these skills from the nurses in their clinical placements. Having a clearly defined view of bad practice and an unclear view of what good practice entails, led students to perceive that the undergraduate programme was focused on what shouldn't be done, rather than what should be done in practice.

"There's no praise, there's no "well done for that" there's no achievements. There's nothing on the wards accept "don't do this, you might kill your patient!", " don't do this... this nurse did this, and this nurse went to prison!". I've seen the posters on the walls saying 'Drug errors happen', not like "c'mon guys, well done. What a brilliant team you are, look at what we are doing for patients!" (FG5-6 3rd year student)

Students lamented the lack of praise that they received when providing good care, and that nurses seemed only ever to be on the receiving end of criticism, cautionary tales and threats of professional misconduct. At the time that the interviews and focus groups were performed, a wider debate about poor standards of nursing care was taking place. Therefore, an emphasis on professional regulation and protecting

patients from poor practice was evidently being reinforced to the students as a part of their professional development in the university. This implies that macrosocial processes were strongly influencing the micro and Mesosocial processes of their professional socialisation. And this was shaping their view of the nursing's professional identity as being under increasing scrutiny from both the profession and the public.

7.2.3 Identifying role models

Students felt, almost intuitively, those nurses in practice that represented the type of nurse that they hoped to be. In the interviews with second and third-year students, they were asked to describe the qualities that they associated with positive role models. All students asked were able to think of at least one good example. However, they sometimes found it difficult to articulate the specific qualities that their chosen role model possessed.

“KU7-3- I have worked with some amazing nurses...and I mean amazing. You know? You just get a certain vibe from them that makes you think “you are just how we all should be!”.

INTERVIEWER- *“What was it about them that made you think that?”*

KU7-3- “Hmm...that’s actually quite difficult to put into words. Like I say, it’s just a sort of vibe that they give off. Maybe it is the way that they are with people...you know? Sort of calm and in control. I don’t know, it’s really hard to say.” (KU 7-3 2nd year student)

Identifying role-models in practice appeared to be a tacit process that was guided by a feel for how certain nurses interacted with other nurses, and their patients. When encouraged to describe specific behaviours that they had observed in these nurses, students’ responses fell into 4 themes:

- 1) the ability to remain calm under pressure
- 2) being a team player
- 3) demonstrating compassion
- 4) being knowledgeable

“Well, there was one nurse on my last placement who really stood out for me. She was quite newly qualified...I think that she qualified about a year ago. And, even though it was a really busy ward, she just seemed to take it all in her stride, I never saw her flustered or stressed about things, she just got on with her work and...well she never stopped being nice!” (KU9-2 2nd year student)

The ability to cope with pressure and to maintain an image of calmness was frequently cited in these responses. Students would sometimes counterbalance this observation with statements about their own levels of anxiety about working in the same conditions. It appeared that they desired the ability to remain calm under challenging circumstances, and that it was this quality that they hoped to acquire in the future.

“There was this really bad shift and everything was going wrong, we were short staffed, a patient had died, there were a couple of really sick ones in my bay, you know, just ultra-busy. Anyway, it all got a bit much for me and I went off into the coffee room and had a little cry. I was thinking “I can’t do this, this is all too much for me”. [the nurse] came in and saw me. She didn’t say anything, she just gave me a hug. And I was blubbing and saying “I’m sorry, this is just too stressful”, and she just went “Don’t worry, you’re doing great! You get days like this, but you’ll be fine”. She was just so lovely and made me feel a bit better about it...so, I’d really like to be like that, you know...sort of bullet-proof.” (KU7-1 2nd year student)

It was difficult to establish whether students wished to acquire this ability to cope with stress because that is what they associated with being a professional nurse, or

whether they were hoping to develop the coping skills needed for survival in their daily work. As such, the role-modelling that students discussed was primarily about identifying nurses who were supportive of them and possessed personal qualities that the student desired, and less about them being exemplars of good professional practice. Students recognised how good teamworking contributes to a more harmonious working environment. The teamworking described was focused on providing effective nursing care by ensuring that other members of the team were able to work well with one another.

“If you are in a good team it's brilliant. Like everyone gets on and everyone is pulling in the same direction. But when it doesn't work, it really doesn't work and there's a lot of division and a lot of... "who does she think she is?" and "doesn't she think we're already doing that?" and all this sort of thing, and...yeah you do get...everyone just gets a bit snappy with each other. You can see people go "oh, I'm not going to do that because she wants me too. No, I haven't got time!". And it's the patient is the one obviously stuck in the middle of these feuds, but when it works well it's so good!". And it does work well.” (FG6-4 3rd year student)

Role-models who were able to create a good teamworking environment were often identified by the students. It was recognised that team leadership was a quality that student's valued and wished to develop following registration. Being organised, leading a team, having good communication skill and yet, still being committed and patient-focused, were all qualities that students wished to obtain.

“She got on with all the patients and she wasn't lazy and was really on top of things she wouldn't think "oh I can't wait to get out of here", if she had to stay

back an hour after she finished to get things done, she would do it. She would make sure everyone was doing their job properly and she was quite dominant. But at the same time, it was good because it was effective and really got things done. She was good at organising what she had to do, and she provided really good quality care to patients. You could see that the patients were happy and the Drs that she worked with were very happy with her and it was just a happy environment. She was an allrounder and that is what I am aiming for. ” (FG10-3 3rd year student)

The leadership and management of care was emphasised in the responses of the third-year students. Being near to the end of the programme, these students were starting to identify with nurses who possessed the skills needed to organise themselves and others in the delivery of care in complex and frequently changing situations. The final year students were preparing themselves for registration as a professional nurse. Whilst there were still some references made to these nurse's ability to be kind and compassionate towards the students, the overriding ability that the role-models possessed was to be able to manage care environments. This correlates with their interpretation that poor management is partly responsible for failing care standards (see section 8.1.2).

Student's valued nurses who were not only knowledgeable but were able to share that knowledge. Role-models were identified who were able to pass their knowledge onto to students and also could use that knowledge to communicate more effectively with other members of the MDT. The students desire for more knowledge and their

awareness of how much they had yet to learn seemed to support their decision to identify knowledgeable nurses as role models.

“I would love to be one of those positive, motivated and knowledgeable professionals!” (FG6-1 3rd year student)

“There was a nurse on my last placement, she knew so much! She was always teaching us things. And I would hear her having conversations with the doctors about patients and she seemed to know as much as they did...well maybe not as much but she could hold her own..she knew what they were talking about and I didn’t have a clue. I can’t wait to be like that. I still have a lot to learn though” (KI4-3 3rd year student)

Role-models were chosen on the basis of their ability to cope with the demands of what students perceived to be a complex, challenging and emotionally demanding profession. However, there was a strong element of similarity between the role-model and the student themselves; students described the attributes that they shared. When asked to describe the type of nurse that they hoped to become following registration, students strongly indicated the need to become like these role-models: resilient, organised, and knowledgeable. These characteristics were presented as goals for their personal development so that they would be able to cope with the demands of the job. Overall, students identified with role-models who share their individual characteristics as nurses (modelling personal traits), and as being a representation of the nursing profession (modelling professional roles).

7.3 Overview of Mesosocial processes

Over the duration of the undergraduate programme, student nurses learn to reconcile the dual identities of being a university student and a student nurse.

Epistemologically, nursing knowledge and nursing practice are initially viewed by students as being in conflict with one another. Given the wider context of nursing's transformation into an all-graduate profession, students felt that they were caught in the middle of an ongoing debate about what type and level of education nurses need in order to provide safe and effective practice. Furthermore, the identity of the nursing profession- as being traditionally associated with vocational values- appeared to students to be at odds with a more contemporary view of nurses being autonomous professionals. The students revealed how their education in the university and in their clinical placements were perceived in both positive and negative ways (see Table 7-2); each offering the students different opportunities to learn, even though the learning that takes place is often conflicting rather than complimentary. A further conflict was described in which the need for nurses to become more knowledgeable occurs at the expense of having less time in practice to learn nursing in 'real-world' settings. The relevance of the knowledge acquired in the university was not fully understood at the beginning of the programme, and a distinction between theory and practice was more evident. However, as the students acquired more experience, they developed a deeper understanding of how theoretical knowledge could be applied into practice and recognised the nuances of practice that might benefit from a strong theoretical foundation.

	University education	Practice education
Positive	Defining professional standards. Developing academic skills for practice (documentation, science, drug calculations, context-free skills).	'Real world' experiences. Observing role-models in practice. Learning to cope with challenges.
Negative	Non-specific to practice settings. Focused on negative cases. Being taught about 'irrelevant' skills (care, compassion, communication)	Observations of sub-optimal care. Lacking time to learn. Seeing the gap between theory and practice.

Table 7-2- Conflicts between University and Practice learning

Learning the theory underpinning communication skills is given as one example of how students explained how they learned to apply theoretical aspects of communication into practice situations. Furthermore, students developed a more discerning and critical view of the role of theoretical knowledge in practice. Some resistance was expressed about being taught abstract concepts such as caring and compassion. This became more noticeable as students progressed through the programme. In the first year, students appeared to absorb, uncritically, the need for this component of the curriculum. These students described how theoretical knowledge was now a necessary requirement for a profession that has had to move away from its apprenticeship style training and vocational roots. However, by the end of the programme, students became more aware of what knowledge would be

most applicable to their development as a practicing nurse, and what might be unnecessary to this aim.

A key influencing factor for students, as they learned how theoretical knowledge could be used to underpin nursing practice, was the identification of positive role-models in their clinical placements. These role models demonstrated the importance of being knowledgeable as a component of being a competent and effective nurse. Towards the end of the programme, students witnessed how nurses could use their knowledge to communicate with other HCPs on a professional level, and to share their knowledge with junior nurses and students. The role-models described could reconcile the conflict that students perceived to exist between theory and practice. As such, students appear to be influenced about the importance of theory for practice, more by observing practicing nurses than from their classes in the university.

Figure 7-1 depicts how the relationship between theory and practice are transformed over the 3 years of the programme. It was recognised that students defined theory and practice differently between the first and last years of the programme. Theory and Academic knowledge were synonymous in the first year; these describe a broad range of topics that are abstract in nature (science, ethics, communication, caring etc). Practice skills were described as physical tasks, and sometimes referred to as 'basic care'. Later year students, defined knowledge that was more specific to practice (knowledge of drugs, multi-disciplinary communication, leadership skills etc). These students did not describe practice without it being underpinned by knowledge. The role-models that they described exhibited knowledge-based

competence. Therefore, the role-model presents students with ways in which abstract theory can be interpreted into competent practice, where lectures and classes in university were unable to do so.

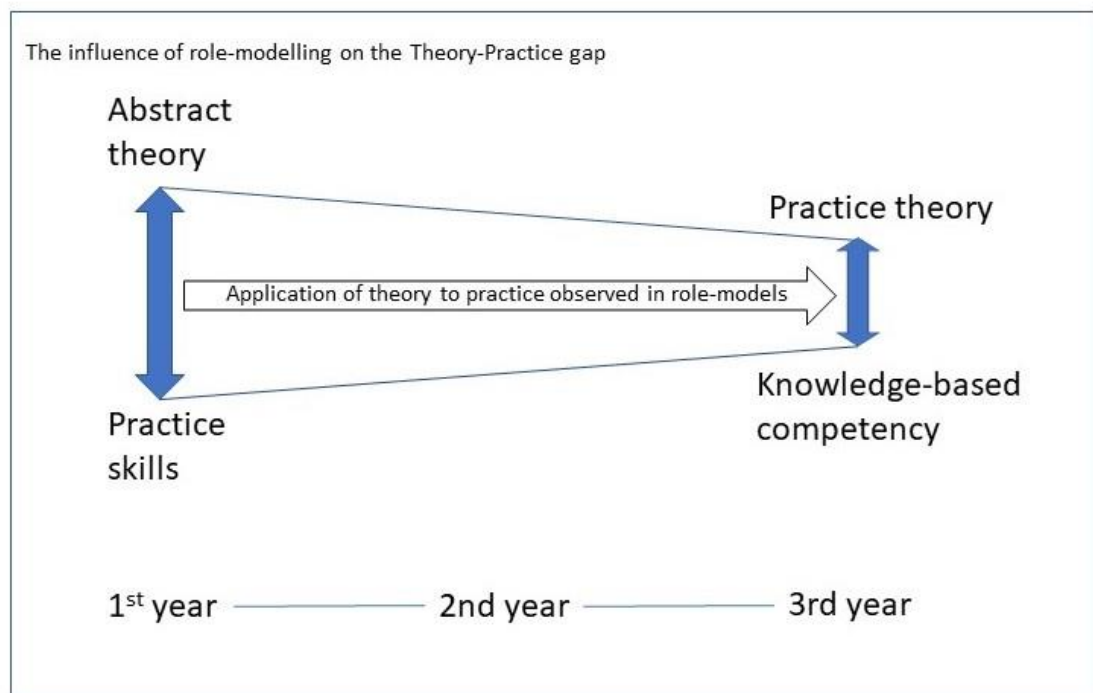


Figure 7-1- Theory-Practice gap as it is transformed by role-modelling

At the time of these focus groups and interviews, students were trying to reconcile the conflict arising from the transition between old and new approaches to nurse education. The sustained pressure for the profession to be transformed was felt to be a burden that they, as the next generation of nurses, would have to carry. Whilst accepting that there was a need for the profession to cut itself loose from its traditional vocational roots, students were daunted by the way that this conflicts with

their need to ‘fit-in’ on their placements, whilst simultaneously feeling different to the nurses that they would be working with. The need for them to be the ‘new generation’ of nurses, they felt, was a response to publicised care failings under the current system of nurse education. Other factors for these failings were cited (see section 8.2.1) but the acquisition of a nursing degree for registration was described as essential to raise future care standards. The high-profile criticisms of nursing care were not only experienced through public media but also ran through all aspects of the students learning; be that in the classroom, or in practice placements. The seemingly constant reinforcement of negative cases and requirements to report poor practice led students to perceive much of their education to be about learning *what not to do*, rather than *what should be done*. This presented an image of the nursing profession as being a failing system, rather than inspiring positive images of nursing’s professional identity. It was only when, in later stages of the programme, that students were able to identify positive role-models that could counterbalance the negative images projected to them in the first year of their career. Negative images of the nursing profession cast a long shadow across the early construction of student’s professional identity.

8 Analysis of Macrosocial Processes

Macrosocial analysis of the data reveals the relationship between the individual and the broader social influences that define social norms of the profession. Institutions such as government, professional regulatory bodies, and health organisations, create frames of reference for the expected behaviours of individuals within those institutions. Similarly, the student's perceptions of the nursing profession, and their expectations of nurses in practice, have their origins in the social and cultural influences that they become aware of. However, the individual within an institution might have only a limited capacity to directly interact with the institution in the way that they might with those in their immediate social world (peers, mentors, educators etc). Hence, these macrosocial influences are beyond the reach of the individual student, should they wish to alter or influence them directly. Nevertheless, institutions and their prevailing culture create a framework for expected professional behaviour, and define an identity for the nurses and the nursing profession.

In this chapter, the way in which these broad social influences shape the student's perception of nursing's professional identity will be explored. Students discussions about the nature of the nursing profession fell into two categories. The first category (*Regulation of Nursing Practice*) is concerned with the way that nurses are regulated by government, the NMC, and Universities. In this category, the themes relating to the limitations and expectations placed upon nurses' practice, highlight how students perceive a conflict between autonomous practice and rigid Professional regulation. The second category (*Imagining Nursing*), reveals how the nursing profession is presented to, and perceived by the public. This category includes themes that

describe students' interpretations of the profession's public image, and how this image influences their practice, and their own vision of nursing's professional identity. Table 8-1 outlines the categories, themes and salient focused codes that structure the presentation of the findings in this chapter.

Macrosocial	Regulation of Nursing Practice (section 8.1)	Professional Regulation (section 8.1.1)
		Political Regulation (section 8.1.2)
	Imagining Nursing (section 8.2)	Experiencing public media criticism (section 8.2.1)
		The professional Imagination (section 8.2.2)

Table 8-1 - Macrosocial influences and processes

8.1 Regulation of nursing practice

Students defined nursing as a highly regulated and rigidly structured profession upon which strict limitations on behaviour are placed. Their discussions were primarily focused on professional regulation through the NMC's Code of Conduct (*'The Code'*). Mechanisms by which this code of conduct infiltrates all aspects of nursing practice and defines expected behaviours, were evident throughout the data. The enforcement of certain elements of the NMC code demonstrated some difference of opinion between the students about how this regulation potentially conflicts with their own perception of professional nursing practice. For some students, the NMC code represented a baseline (or minimum expected standard) upon which all other nursing activities are built. For others, the code provides a delimitation (or boundary) within which acceptable professional behaviours are found. In both cases, a framework for defining *good* and *bad* nursing practice is presented to the students, against which they aligned their own perspectives about other nurse's behaviours.

Political regulation of the nursing profession was not discussed explicitly. However, the role of government in shaping healthcare through health policy, public sector expenditure and nurse education were identified as indirect influencing factors on the way that they perceived the nursing profession. During the time of the data collection, The Francis Report into the failings of the Mid Staffordshire NHS Trust, was published. Professional and media responses to the scandal, and the recommendations for the future of nursing, dominated students' discussions about the state of the profession. The changes to the way that nurses were perceived as professionals, and as individuals, required students to reflect upon how the

profession regulates the behaviour of its members. Regulation of the nursing profession was found to be both essential and problematic. Students attempted to define their own perceptions of nursing as a profession in the context of these changing expectations from the public, and their own professional bodies.

8.1.1 Professional Regulation

Students recognised that clear boundaries had to be placed on what the profession deems to be acceptable and unacceptable behaviours. Nursing, like other professions, require all members to adhere to the rules and regulations that define these behaviours. When asked to define professional nursing, students frequently referred to *The NMC Code* as the primary frame of reference. Furthermore, ‘The Code’ was described in terms of it being a rigid and inflexible benchmark for professional behaviour. Students did not dispute the necessity for the specific regulatory statements within the code; believing them to be an essential requirement to protect the public from poor practice. However, some aspects of the code were felt to be conflicting, or inconsistent with, their own ideas about good nursing practice. For example, providing care that is based upon evidence-based protocols (NMC 2015: Section 6) were considered to be a contradiction with the provision of individualised and person-centred care (NMC 2015: Section 2). Students explained how the professional nurse should be able to balance rigid evidence-based practice in the context of providing individualised care.

“We know what’s the right thing to do because there’s evidence. But that’s the point because this evidence has come about... but we still have to maintain caring for the individual. I don’t think you should ever take that out of the equation. And having ethical caring from yourself, and evidence so you know what’s right and wrong. So, I think all those things are involved [in being a professional].” (FG3-6 2nd year student)

This humanistic application of research to practice became a notable feature of good nursing, as described by students in their second and third years. This appeared to

result in their observations that Evidence-based practice (EBP) and Person-centred care were, at times, difficult to reconcile. Mostly, this apparent conflict arose from students' own interpretations of the code and how it defines good nursing practice. Moreover, it highlighted somewhat limited views about evidence-based practice and person-centred care; being at opposite ends of a continuum rather than being interrelated practices. Research and Practice were defined as different approaches to nursing in which the nurse must make decisions about patient care that are either: rigidly enforced through protocol or are purely based upon the patients' personal preferences. Evidence-based practice was described in terms of it being 'the right thing to do' in a professional sense; whereas individualised care was defined as being morally right, even when it conflicted with professional boundaries.

"We are spending a lot more time with our evidence and ensuring we're doing things properly and using all the tools available, and that takes time to do, that's still a caring activity, it's based on the same principle, it's just it's not the same caring activity as generally conceived to be a caring activity, and therefore caring visually now looks different." (KI3-6 2nd year student)

Students tried to reconcile the apparent conflict between EBP and Caring by claiming an intrinsic relationship between the two concepts. By viewing caring as an evidence-based activity allowed the students to feel that, despite the current emphasis placed on EBP, that nurses were still attending to their caring role. Hence, despite being compelled to provide EBP, they might still be able to include some degree of individuality in the care of their patients. Furthermore, this re-evaluation of the nature of caring reinforces the earlier finding about how abstract concepts become contextualised into specific situations (see section 6.1.1).

Students described how, by staying within the delimited boundaries of professional regulation, that nurses were protected from the risk of being removed from the professional register and hence removed from working as a nurse.

“You have to uphold the code of conduct. You are accountable for your actions. And you can be responsible for those actions. If you're negligent then you will go to a hearing at the NMC, you will have disciplinary action etcetera, etcetera. You know? You have that professional liability rather than say an HCA which doesn't.” (FG5-5- 3rd year student)

This restriction on their behaviours was frequently cited as a rationale for deliberately disengaging from certain aspects of their work; most notably when defining the boundaries in the nurse patient relationship.

“I don't think you have to lose your character, but I do think that you have to reflect the person that you're treating because, the reality is that you're coming face to face with hugely different people who want different things from you in terms of your professionalism. One of the things as a nurse you learn to do, is to work out what they want. And so, sometimes it's better to be a little bit more formal, and sometimes it's better to be a bit less formal with how professional you are I guess. But then, there's always that underlying kind of professionalism that's a bit different, its more to do with the code of conduct. But I do think it's important to mirror what the other person wants, not just be the same for everybody because it doesn't really work in reality.”
(FG5-1 3rd year student)

There was a distinction made between exhibiting professionalism and operating within professional regulations. Whilst it was recognised that a professional nurse was required to stay within the prescribed boundaries of professional behaviour, the term professionalism was described in a more flexible way; referring to how the nurse should reconcile regulated behaviour whilst still maintaining a relationship with the patient.

“Obviously you cannot cross that line, you have to have a relationship because it is a relationship, but you cannot just cross the line as well, to get too close. ...Obviously making sure that it is not crossing the line which you have probably in the code of conduct. “(KI9-2 3rd year student)

Meeting the patient’s needs and expectations forced students to examine the limits of allowable regulated behaviour, and decide how a balance could be struck between this and what they perceived their patients to expect from them, in terms of professionalism. A clear link was described between abiding by regulatory rules and the type of person that the professional nurse should be. The professional code was described as a mechanism for enforcing nurses to demonstrate specific behavioural traits both in and out of their working life.

“The Code is like a set of rules, and professional nurses have to follow them. it's also a part of who you are, so it's not only that we are professional in our work environment we have to be an example, so how we behave in the local park, or how we talk to people on the street, the minute when they find out that you are a nurse then suddenly they look at you differently” (KI2-2 2nd year student)

In this respect, the NMC code was described as not only a way of protecting the patients from poor practice, but also a process in which nurses must exhibit a set of expected attitudes and qualities. A first-year student described the ‘natural attributes’ of professional nurses that allow them to function within regulatory guidelines.

“I think that the guidelines and protocols are there to kind of keep you on track and make sure that you are doing things properly. As for the natural attributes for being a professional nurse, there's accountability for your own actions, the ability to act within your own limitations, so you know to ask for help if you need to, but to have the competence and confidence to be able to work alone and as part of a team. And consistently deliver good care, to treat all patients equally, as you would like to be looked after. (FG2-3 1st year student)

Students references to the professional code of conduct showed how they see it as being more than just a set of rules, but also as a statement about the type of person that nurses should be; self-aware, confident, moral and conscientious.

Competence and accountability were frequently cited as the essential rules of professional nursing; being deemed clinically competent to practice and also to be able to account for care given, were felt to be the most salient of nurse’s regulated behaviours. However, the ethical and moral elements of the NMC code (person-centred care, dignity, respect for patients’ individuality etc) were spoken about as being distinct from the more objective requirements for competency and accountability. Students associated moral and ethical qualities as being supplementary, rather than intrinsic to, the NMC code. Thus, the NMC code was

used as a shorthand for rules and regulation, and professionalism was used to define behaviours that they associated with being a professional nurse. Furthermore, the behaviours associated with professionalism were differentiated from acting within professional rules by the nurse making them visible to others. There was an implication that a nurse might appear to be professional but in fact be unprofessional below the surface. The need to be transparently professional and not simply acting the part again emphasises the importance placed upon the nurse behaving in an authentic way that is consistent with their own personal values.

“[Being a professional] is about honesty and being trustworthy. Which is the difference isn't it? You can be honest but not really trustworthy. You can be trustworthy but not really honest...they link together but...transparent, yeah, it's there, you can see. Whatever I do, whatever I practice, anyone can see.”

(FG9-1 2nd year Student)

Students described professional regulation as an inevitable and necessary component of being a part of the professional group. They identified this regulation as a means of gatekeeping, whereby only those who are deemed competent are allowed onto the professional register, and those who fail to practice safely thereafter are removed from the profession. But, they also recognised the need to demonstrate professionalism at all times. Nurses are therefore required to do more than just be regulated, they must also exhibit certain behaviours that are assumed to be essential to professional nursing. Students made these assumptions based upon their interpretations and understanding of the regulatory guidelines. In section 6.2.3 (page 243), acting in a professional manner, and giving off an image of being a

professional, were identified as microsocial processes that served two purposes: for students to gain the trust of patients, and to earn the respect of mentors. This macrosocial analysis of the students' descriptions of professional regulation reveals a third reason for acting like a professional; that the students perceive the NMC to expect that nurses exhibit specific affective traits that reflect an image of professionalism. In this respect, the imperative to perform a function in a highly regulated way originates at a macrosocial/professional level, and subsequently permeates down to the microsocial/individual processes of daily practice. Competency was given as an example of how nurses should not only effectively and efficiently carry out certain skills, but also that nurses should also be capable of communicating (non-verbally) that they are confident and trustworthy in carrying out those skills. Therefore, students describe competency as more than that which is defined by the NMC Code (as a means of protecting patients against unsafe practice) but extends into attitudinal and affective domains of practice whereby nurses provide reassurance and gain patient's trust. Students therefore feel compelled to 'look the part' of the professional, even if they feel that they lack the competence.

"To be professional, I should know what I am doing. I should be able to carry out the tasks that I need to and look professional at all times. Be able to communicate with the other healthcare professionals...you know, the whole NMC code basically (laughs). And be able to be competent and be able to do things without doubting myself. Simply because if I know why I am doing it and I know how to do it, then that is fine, I should be competent in doing something. My mentors would only allow me to graduate if they thought I was good enough to qualify, and the patient's probably wouldn't let me

anywhere near them if I looked incompetent anyway!” (KI10-3 3rd year student)

The professional regulation by the NMC was described as a ‘baseline’ and an absolute minimum requirement for professional practice. Adhering to the NMC code rigidly but not performing above this expected minimum, was an exemplar of poor practice. Students perceived that professional nursing practice should go above and beyond the minimum requirement and should be demonstrative of behaviours that are consistent with broader expectations that are placed upon nurses (Figure 8-1). These expectations were defined as being consistent with behaviours that they believed patients wished to observe in the nurses caring for them, and also from their own prior expectations of how nurses should act.

“Ultimately, I think it is to do with, if you have succeeded in providing the care that was, was expected of you, from a patient, and what you expected to give to a patient, then I think that's professionalism.” (FG 1-3 1st year student)

From their examples of professionalism in nursing practice, and role models that they had observed in clinical placements, students described how, the more that nurses exceeded the minimum expectation, the more likely they were to be perceived as excellent nurses.

“I’ve learned that good nurses do their jobs well...they’re competent in what they do. Then there are these other nurses that go above and beyond that, they are prepared to go that extra mile when they have to” (KI2-2 2nd year student)

Moreover, they anticipated that the ability to provide care that is safe, based on sound knowledge and demonstrates caring, is an expected standard for professional nursing. Any practice that fell below this standard (the upper arrow in Figure 8-1) was considered to be less desirable.

“there are those nurses who just do enough...they aren’t bad nurses, you know? They do what they have to do and go home...they are good, but they aren’t great, if you know what I mean?” (KU7-3- 2nd year student)

Practice at or below the provision of safe care (lower arrow) was described as unprofessional. Hence, safe practice alone was not considered to be evidence of professional nursing, and not that which students aspired to.

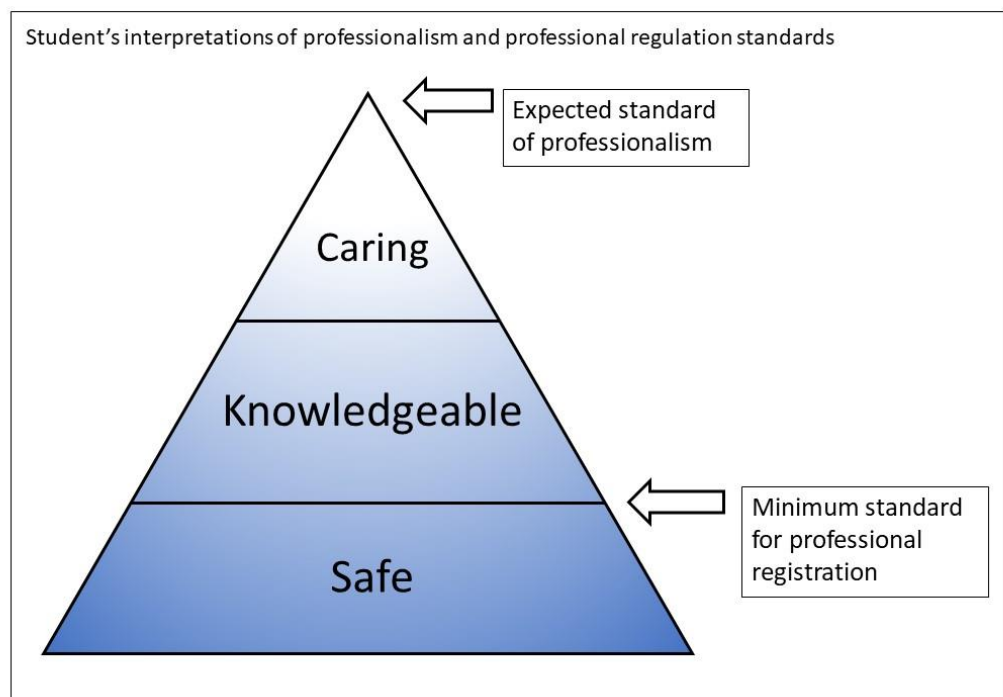


Figure 8-1- Student's interpretation of professionalism

The strong relationships that nurses should form with their patients (as described in section 6.2.1) were highlighted as essential elements of professional practice by

students. However, the NMC code does not describe this as a specific requirement for professional practice. Students noted a disconnect between being required to engage with patients on an emotional level and the provision of professional nursing care (as defined in the NMC code). Providing person-centred and individualised care was felt to be incompatible with other parts of the NMC code that cautioned against crossing professional boundaries in nurse-patient relationships.

“You’ve got to follow the code but some people are too clinical about it and, you know, they get accused of being not compassionate and stuff. It’s just that you’ve got to be the best of both worlds somehow. (FG5-3 3rd year student)

Students recognised that patients’ expectations were sometimes in direct conflict with those set out by the NMC. They felt that they were trying to manage with a range of competing expectations that had been placed upon them.

“I appreciate now what a complex role it is, it’s so multifaceted in terms of what you are expected to be, and sometimes I think that what people expect a nurse to be is impossible. It’s like an impossible thing. I try my best but the expectations, you’ve got so many different things that are expected of you that to try and fulfil all these criteria, you know, is impossible.” (FG5-1 3rd year student)

This conflict was further compounded by the way that students described the need to respond to Patient Experience Evaluation Systems and the nursing profession’s response to high profile criticisms of nursing care (see section 8.2.1).

Professional regulation of practice was not only described as being that which is enforced directly from the NMC but also via a mechanism of self-regulation.

Students described ways that they should not only monitor their own practice but also that of other nurses that they worked with. Identifying good and bad practice was felt to be as much the responsibility of the nurse as it is for the NMC; nurses acting as gatekeepers for the profession. Recognising and reporting examples of poor practice were essential aspects of nurse's responsibility. Even among the first-year students (who had yet to have their first clinical placement) had been made aware of their responsibility to report poor practice.

“When we are in practice out there, we have to... it is our profession, it is for us also too, before it goes to that level, if somebody could have seen...it doesn't happen all of a sudden...somebody from the profession should have challenged them. If we see something we can... we shouldn't be sleeping on it. we have to deal with it. I mean, it's a problem. But these bad apples, we have to deal with it. (FG8-3 1st year student)

Students explained that they had received instructions from their universities to raise any concerns that they might have about the practice that they witnessed in their clinical placements. The importance of protecting patients from malpractice was given as the primary rationale for students to become a part of the surveillance culture of nursing practice; the individual nurse's accountability therefore extends to the actions of other nurses. Students also cited this requirement as a means of defending the profession against negative criticisms of care that had been seen in the public media. Students considered themselves to be a part of the collective responsibility to police the behaviour of nurses in practice. The criteria against which good and bad practice could be measured was based upon the NMC code as well as their own perspective of what should constitute good nursing practice. Poor practice was perceived to result from not following the rules or lacking caring behaviour.

The NMC Code provided the students with an objective measure of practice; nurses were either *following the rules* or not. Where poor practice was identified by this measure, students attributed the cause to be a result of ineffective clinical management:

“If things are not being done properly, it is down to bad management, and management not picking up... maybe not employing the right people for the role and not picking up on people who are not really good team members, and not really working well.” (KI13-1 3rd year student)

“I’ve seen situations where nurses are obviously being put up into a role of management and they have not got the skills. I mean, I can see that they are very caring they are desperately doing the job that they are trying to do but they are not managers and actually the patient is suffering because the other nurses don’t know what to do.” (FG3-2 2nd year student)

However, *lacking caring behaviour* was viewed more sympathetically by students; believing that the nurses in question were behaving in this way due to being overworked, or becoming stressed by their working conditions.

“I do see a lot of nurses lacking compassion, there are some people that I have met that just don’t seem to care anymore, they don’t care what happens to their patients. I think they did care at some point but I think they just get to the point where they think that they just can’t cope anymore and they get burnt out.” (KI1-1 2nd year student)

The effect of stress, caused by low staffing levels and high workload, was described as the most likely explanation for nurses to lose their ability to be caring. Students

had sympathy with these nurses and described them as victims of poor working conditions and ineffective management rather than being intrinsically bad nurses.

“No one starts out wanting to be a bad nurse, I think that it just happens over time when you are stressed. And if you don’t get supported by your manager then I guess that you lose some of that caring that you had?” (FG11-1 1st year student)

Students described how nurses became victims of poor working conditions, and that the poor care that the professional regulators were guarding against was not necessarily due to nurses being uncaring. The underlying causes of the challenging working conditions that they observed (lack of staffing and the lack of time to deliver optimal care) were felt to originate from systematic failures of healthcare organisations to provide the right culture for good nursing care to take place.

“it’s short-staffing and people being run ragged that’s causing the problems, it’s not a compassion deficit!” (FG6-4 3rd year student)

The professional regulation of nursing, via the prescription of minimum acceptable standards of competence, gave the students an objective measure with which they could evaluate care quality. However, the professional attitude of nurses (that they defined as professionalism) appeared to be judged in a more subjective way; being based upon a broader perception of how a nurse should behave towards their patients, that is not prescribed by the NMC code, but implied by the student’s interpretation of it.

8.1.2 Political Regulation

The students in this study understood that a publicly funded healthcare service inevitably fell under the control of the UK elected government. Issues regarding healthcare funding, staffing levels, and health and social policy were identified as being the responsibility of the Department of Health. However, the students expressed dissatisfaction with the way that political rhetoric often portrayed the nursing profession when issues about healthcare were being discussed in the public sphere. The recent public and political debate about the Mid Staffordshire NHS Trust, and the publication of the Francis Report (2013) had opened up new questions about the state of nursing, and of the NHS in general. Unsurprisingly, due to the high profile in the news media, students made frequent references to these events in the focus groups and interviews. The students recognised the need to identify poor nursing practice wherever it was found and to ensure that patients were not exposed to inadequate care. However, they felt strongly about the way that they felt that nurses were being used as ‘scapegoats’ to defer the attention away from, what they saw as, inadequate healthcare policy and harmful political interference in the nursing profession.

“I think that this is scaremongering on the fact that [politicians] are targeting us again, as scapegoats because we are the face of healthcare. I think that nurses are the face of healthcare and they get stick for everything that is wrong with healthcare because we are the ones that have initial contact with patients as they come in and we have the most contact with them and we are the most reasonable people in the world. So, I think whenever anything sensational comes out it more or less always targets nurses; "nurses

are not doing enough, nurses are not doing this..." it's never the case of saying... that it is to do with funding...or austerity. People not being prepared for what they are doing and those who are doing it not being resourced enough, you know the wards are not resourced enough!" (FG9-2 2nd year student)

Another second-year student described how her interpretation of being a professional nurse was shaped by other macrosocial influences:

"I suppose we've been told what to look out for..... Like with these 6C's, we were all given a little card with them on in the first year. And we were shown the RCN video, you know, the "this is nursing" video? So, I suppose that gave me some kind of idea. But before I started I think I had an idea... I knew what I didn't want to be." (KI1-1 2nd year student)

The 6C's of nursing generated some difference of opinion between students at the beginning of the programme and those in the mid and latter stages of the programme. First year students recognised their own characteristics that were reflected in them (especially, caring, compassion and commitment); these being viewed as essential prerequisites for joining the programme. Courage, competence and communication were anticipated as qualities that would be learned and developed as they would progress through the programme towards registration.

"You have to be caring and compassionate to want to be a nurse anyway. You wouldn't come into the profession and put up with all the tough times on the course if you didn't really have the drive to become a nurse. Those other things, I think you learn them as a student anyway. You should have all those 6C's down by the time you qualify" (FG8-1 1st year student)

However, second and third-year students questioned the motivation for- what was seen as- a political enforcement of behaviour that added nothing to their existing philosophy of nursing.

FG12-2- *"...don't get me started on those 6C's! What a load of crap!*

Seriously, what is the point of telling nurses that they have to be caring and compassionate and all that? That's what nurses are already like. Sure, there are a few bad apples out there but the NMC already have ways of dealing with them.

FG12-6- *"yeah, it's stating the obvious, isn't it?*

FG12-8- *"I think that it is just the government showing the world that they are doing something about what happened [in Mid Staffs]. It's just politics, it's not going to change anything because we are already doing all that stuff anyway"* (3rd year students).

Students expressed their dissatisfaction at the implication that the 6C's were being used as by the government (via the Chief Nursing Officer of England) as a rhetorical device to portray nurses as lacking in specific qualities (caring, compassion, courage, commitment, competence and communication skills), in an attempt to deflect attention away from other problems. They perceived the failings of the health service to be a result of governmental neglect rather than originating from poor nursing care standards.

"We don't lack caring...we lack nurses!" (FG9-2- 3rd year student)

Students looked to professional bodies, such as the RCN to provide a defence of the profession against these criticisms but were surprised by its absence.

FG7-5 – “In this [newspaper article] it says it's the RCN chief who's saying that new nurses lack caring skills. That's like the person we are all meant to look up to... “

FG7-6 – “I wish I hadn't joined the RCN now! (laughs)”

FG7-7 – “They should be on our side! “

FG7-5 – “Yeah, you'd hope that out of anyone who would not have faith in nurses, you'd hope that they would have faith in nurses.” (FG 7 3rd year students).

Students perceived nurses to be the victims of political rhetoric; being targeted as those most responsible for the poor standards of care that had caused public outrage. They recognised that some nurses were clearly operating below expected standards but did not feel that those nurses were inherently uncaring. Instead, they suggested that those nurses had been negatively affected by managerial, professional and political inadequacies. Furthermore, they felt that the profession itself was turning against itself by not providing an adequate defence against criticisms from outside of the profession.

“[criticism of nurses] just shows the poor representation of nursing on a national level. This wouldn't happen in any other profession of this size. Any other profession would hit back. Well, we can't strike, can we? But I think something would have been whipped up a bit more if this happened to another profession of this size, and with such attacks every day. (FG12-4 3rd year student)

The apparent lack of public voice from professional bodies against criticisms of nurses, and being unable to take industrial action against- what they believed to be- the underlying causes of the problem. This led to a perception of the nursing profession as being helpless and passive in its ability to defend itself against criticism, and to influence policy. However, being asked to vicariously monitor the behaviour of nurses that they worked with (by raising concerns about poor practice) was not questioned, as they saw it as an essential part of their own professional responsibility.

“The Courage bit...having the courage to blow the whistle on bad practice, I get that, that makes sense, we should all be doing that, but the others...I don’t know, it feels like, it’s like... whenever something goes wrong, we get it in the neck. And instead of us saying “no, that’s not right!”, we seem to just roll-over and take it...actually, we don’t just take it, we sort of apologise too, it’s like “sorry sir, we’ll try harder next time...it won’t happen again”. (laughs) It makes us look kind of weak”. (KU10-2 3rd year student).

Students expressed concern about the profession being seen as lacking a voice against, unfair and unnecessary political rhetoric. The real problems that they observed in practice (low staff morale, insufficient staff numbers and poor management) were the factors that shaped their view of the nursing profession as passive and powerless.

8.2 Imagining nursing

The image of nursing, as viewed from those outside the profession, shaped the professional identity of nursing for these students. They were aware of how others imagined the nursing profession to be and reflected on how these perceptions impacted on their own views. The way that nurses are imagined or visually represented by non-nurses provided an insight into the influence that public image has on students before and during their nurse education programme. As described in section 6.1.2 (page 209), close friends and family influenced the students' decision to join the profession and formed an early image about nursing as a profession. As the students progressed through the programme, they became aware of how other external influences shaped their understanding about how the nursing profession is viewed by society, and how this influences nursing's identity.

This study was conducted during a period of time in which nursing was under a spotlight. The recent change to nurse education, through the mandate to make all registering nurses graduates, was still being debated at the time when the Francis Report into the Mid Staffordshire NHS Trust failings was published. It was against this backdrop that students were discussing their own views on the professional image and identity of nursing.

8.2.1 Experiencing public media criticism

During the debates about the transformation of nursing into an all-graduate profession, a concern was frequently raised in the public media about whether this change diverts student nurses' time away from learning clinical skills, towards an emphasis on them achieving academic credit for a degree award. The trope "too clever to care" became widely used as the embodiment of this change of emphasis, by those who felt the change to be a negative one. The students were particularly affected by this criticism being directed at the nursing profession. Their own status as undergraduate student nurses made them particularly sensitive to these criticisms, and they used words like 'confused', 'frustrated', 'feeling rubbish' and 'damaging' to describe the impact that these negative viewpoints had on them.

Students were asked to comment on newspaper articles that suggested that modern nurses had become less caring as a result of this change (see Appendix 9); there was widespread condemnation about this view among the students.

FG5-6- "This 'too clever to care' thing I think is, is..."

FG5-3- "...bullshit..."

FG5-1- "for a start, it's insulting, it's insulting to think that you have to either be clever or you are caring, there's no..."

FG5-6- "it's not a cogent argument"

FG5-5- "it's completely irrational!" (FG 5 3rd year students)

Discussions about this statement revealed how the students perceived contemporary nursing and nurse education. They expressed their belief that the two concepts (cleverness and caring) are not mutually exclusive and are inextricably connected.

“Surely you have to be clever AND caring, don’t you? Are they saying that if you are clever, you don’t care?! I am confused.” (FG7-3 1st year student)

Their reactions were as much surprise as they were anger. The disbelief that one could be caring without also being clever demonstrated how they interpreted caring; not just as a way of caring about their patients, but as a signification of how nurses perform highly skilled tasks in a way that are humanistic and individualised.

“That it is more than being caring. You have to have the confidence and you need to have the drive. It’s about...it encompasses a lot of skills and qualities about a person and I still don’t know all of them but I feel that it might start from being a caring person or having an interest in a particular field of nursing or healthcare, but it then goes on to practical skills and science; it goes on to sociology and psychology and physical health, and you learn about yourself as well.” (KU9-1 3rd year student)

Despite the concern being expressed by this newspaper article- that nurses time is being taken away from the bedside to concentrate on “more technical tasks”- these students interpreted the headline as a view that nurses do not need to be highly educated, and that their tasks should not require great technical skill.

FG 6-1 “But does being extra clever make you less caring? I don’t understand... is there a limit to us?”

FG6-6- *“yeah, why does learning this make you any worse? It's just like ‘go and empty our bedpans and don't think about it!’.”* (FG 6 3rd year students)

Their interpretation of this statement was that *clever* was referring to academic ability or intelligence, and that *caring* was being used in its adjectival form to describes nurse’s attitudes, rather than as a verb to describe nursing practice. Moreover, they were dismayed that nurses were perceived to be uneducated, and only worthy of fulfilling menial tasks. The students generally responded quickly to the headline before reading the accompanying article. This offers an insight into how the 4-word trope immediately produced a reaction to the way that the students felt that nurses were being judged by the public.

“I don't think anyone would go into this job if they didn't really care. The fact that you...because a lot of people think that now you have to do a degree, you must not care anymore. Which I think is the complete opposite because if you didn't really want to be a nurse why would you go through the whole process; it's not an easy process is it?” (FG10-1 2nd year student)

The students’ spontaneous association between the words in the headline and their own ideas about what the words were implying, reveal the disconnect between their own perception of nurses and what they believed the public thought about undergraduate nurse education. The headline’s implication was to generate the impression that nurses ‘no longer care’, despite the article being about a perceived change in the nurses’ role from ‘providing bedside comforts’ to the ‘concentration on more technical tasks’. The students instinctively related this public criticism of the nurse, to the mandatory requirement of a degree in nursing for entry onto the professional register. Students rejected the perception of the public media that

portrayed them as academic but uncaring. They gave examples of how, in order to deliver good nursing care, the nurse is required to have a wide range of skills and knowledge. They recognised that nursing in the past was different to how they see it today and that the role requires nurses to attend to many roles that were not part of the nurse's function previously. The negative public perception was, they believed, to be a product of anachronistic imagery of nursing and a lack of understanding by the public about how nursing has changed. This perception was described as originating from historical images of nurses that are still held strongly in the public imagination.

FG4-2 - *"Maybe the role of us has changed whereas the view of us in society hasn't changed."*

FG4-1- *"No, it hasn't changed!"*

FG4-5 - *"it needs to catch up"*

FG4-2 - *"but do you think it ever will?"*

FG4-1 - *"no"*

FG4-2 - *"because there's the whole, there's still that whole image of Florence Nightingale..."*

FG4-5 - *"but that's how they **want** to see nurses though"* (FG 4 2nd year students)

Visual imagery was strongly associated with the view of a nurse as being a historical symbol of vocational selflessness. The nurse as a human embodiment of an angel and only wishing to do the best for the patient was counterbalanced by a more modern image of nurses, as professionals with knowledge and expertise in an increasingly technological environment.

FG3-2 – "We're not seen as the angels we used to be."

FG3-1 – “I think that comes from the fact that nursing... where nursing comes from, originally, centuries ago, nursing was about cleaning vomit and cleaning bottoms. And it took a really special person to actually come and do it voluntarily or go and give yourself up for that kind of work. And if you were that kind of person that would be really strange if you actually hurt or abused someone. So, that now that nursing has changed, and it takes more than that and our tasks are different, it takes different kind of people” (FG 3 1st year students)

The images of nursing, upon which these stories were built, were thought to be a result of pre-existing historical stereotypes, that had no basis in reality. This image conflicted with the student’s notion of the contemporary role of the nurse; historically the nurse was at the bedside, and now the role required more attention being paid to administrative and technological tasks. Because of this, students felt that they might be perceived to be 'slacking' if they were not always present at the bedside. This dissonance between external expectations and the reality of practice were expressed as being to blame for much of the criticism levelled at the profession.

The media stories about poor standards of nursing care evoked strong defences from the students. These stories were rationalised by describing them due to ignorance about the role of the nurse, and from other generalisations about nurses. These stories in the media were generally discredited, although their impact on the students was evident through their reactions to them. However, the influence of the press on shaping public opinion was not underestimated. The media portrayal of this ‘new generation’ of nurses, and the way in which they are now educated, was felt to lead

to a devaluation of the degree that they were taking. This subsequently led to students feeling that the profession's status was perceived poorly by other professionals, and by society as a whole.

"[newspaper reports] are all very sweeping generalisations, it's like, not every single new nurse is going to lack care. There may be some out there, there's always good and bad in everything. It just kind of devalues your degree to some extent." (FG1-1 1st year student)

The impact of this criticism on the participants view of the nursing professions identity provided an impetus for the students to prove people wrong, by working harder to redress the balance.

"When I see these kind of headlines in the papers, it drives on to prove them wrong, be better in the future" (FG4-5 2nd year student)

As with earlier comments about the profession's response to criticism (section 8.1.2), there was a noticeably passive acceptance about the criticisms targeted at nurses. Despite the strong reactions that students clearly had towards being labelled as 'uncaring' (dismissing it as inaccurate or a generalisation), they felt that they lacked the power to change public perceptions other than by trying to overtly appear to be caring to their patients.

"Because the patients have probably heard bad things about the state of hospitals and the NHS when they come in, I try and dispel the myth a bit. It's not that I am not caring, I think that I am, but I try and come across like I am super caring...I can be overly nice, much more than is natural for me (laughs). I guess that I am overcompensating for all the negative stuff that you hear about in the papers" (KI 8-3 3rd year student)

A picture of overcompensation for the perceived failings of the profession is once again evident. This time the behaviour was intended to correct the misconceptions of the patients, rather than the political rhetoric of the 6C's. Student's perceptions of the nursing profession were profoundly influenced by the public media image of nursing, as having lost its roots as a vocation, and of nurses as lacking in their ability to care. The transition to an all-graduate profession clearly provided a backdrop for much of this criticism, along with high profile exposure of failing NHS hospitals. The media portrayals of nurses angered these students as these views did not concur with their own perspectives on nursing's modern identity as a highly skilled and technical occupation. Students were aware of how this negative image would potentially prejudice patient's expectations and experiences, of being under the care of a health service that is portrayed as failing.

"And they come to hospital expecting bad things so good things happen all day and one bad thing happens and they're like "I knew this would happen, this is awful" rather than being like "no, actually there's really good things, maybe they don't have quite enough time, but they've done the best that they can in their time". And this sort of thing makes people come into hospital with a negative attitude and it's so hard to change a negative attitude back to a positive one." (FG4-5 2nd year nurse).

Taking on the role of an ambassador for the health service connects with student's associations between the nursing profession and the NHS, with nurses being viewed as the 'face' of the NHS (explored further in section 8.2.2).

Students described how they adapted the behaviours that they felt that their patients expected from them: being highly visible, having an increased presence at the bedside, appearing to be caring and compassionate, being human and relatable, and going ‘the extra mile’ (see section 6.2). Hence, microsocial processes of individual behavioural adaptation, were strongly influenced by the negative public media criticisms, which shaped their perception of nursing’s professional identity.

8.2.2 The Professional Imagination

The way that the profession presents itself to the public and to its own members provides a framework of professional identity for the nurses within the profession. Representations of nursing that originate from the profession itself underpin the ways that students learn to align themselves with a goal or target identity as they progress through the undergraduate programme. Students were aware of some of the more widely perceived aspects of nursing's professional identity. As seen in the microsocial analysis, students had their view of the nursing profession shaped by early experiences of healthcare, and from the influences of friends and family, when making the decision to join the profession. The processes by which these influences were internalised were primarily microsocial, since students actively reflected on their own self-concept when considering their suitability to become a nurse. However, the origin of these influences can be largely attributed to the macrosocial processes that present the nursing profession to the social world, outside of the profession.

Students made references to the professional imagery in many of their discussions about nursing. Much of this imagery was tangible and visible; such as the wearing of a uniform, and the expressive and affective behaviours that are generally associated with nurses and nursing. This imagery also took the form of a more tacit- and difficult to articulate- idea about the role, function and status of the nursing profession in the modern world. The less visible imagery drew upon historical and vocational elements of nursing's identity. Four symbolic representations of nursing were identified that were focused around certain social practices (see Table 8-2).

Each of these symbolic representations were derived from broader social ideas that are reproduced through professional bodies, education institutions and public media.

Explicit (visible) practices	Tacit (invisible) practices
Wearing a uniform	Behaving selflessly (having a vocation)
Making time to be present (a cup of tea)	Having a sense of duty

Table 8-2 Student's symbolic representations of nursing

Wearing a uniform, whilst not being a requirement for nurses in Mental Health and Learning Disabilities nursing, was referred to as a defining symbol of nursing. Many other areas of modern nursing do not require nurses to wear a uniform (Emergency department, Operating theatres and Intensive Care Units for example) but instead, ‘scrubs’ or single use gowns are worn instead. These garments are also worn by medical and allied health professionals in those areas. However, the pervasive reference to ‘the uniform’ was frequently used to describe the visual representation of nurses at work, whether an actual uniform, or other specific apparel, was being worn. In either case, students clearly recognised that there was a strong visual element to the nursing identity. The association between the wearing of a uniform and taking on the role of a professional nurse was described.

“When I have the uniform on, it boosts my confidence a little bit. Your level of responsibility... that goes up when you have the uniform on and you have to act confident in your knowledge.” (FG10-3 3rd year student)

“Even when everyone is wearing scrubs, you can usually spot which one’s are the nurses...they kind of look different somehow.” (KU9-1 2nd year student)

The uniform was used to define a boundary between social self and professional self; the donning of the uniform marking a delineation between being a professional at work and being themselves out of work.

“I think people forget that, a lot about being a nurse, is that there's the face that we put on, we're very professional, we'll go in and we've got the uniform on and that's fine, but there's all this crap going on in our lives behind us. So, it's trying to kind of keep a lid on that and I suppose it's just, it's hard when you know, you're going in professionally like a lot people would go into an office job. (FG6-3 3rd year student)

Creating distance between the nurse and the patient was an important aspect of wearing the uniform. Despite the uniform being an iconic symbol of nursing (and a representation of being a caring professional), it could also be used to delineate personal and professional behaviours. The nurse’s uniform therefore provides a screen behind which students could retreat if they wished to establish a more formal and distant relationship with the patient. The professional distance that students perceived the uniform to give them enabled students to establish the terms of reference for their relationship with their patients.

“The patient has still got to know that I am a nurse and I am still a professional, so they can't just talk to me like a friend. They need to talk to me like a professional here. And if you ask them "is there anything else that I need to know?" they need to know that they can trust you as a...to keep any

information that you are given...and act on it. They rely on you sometimes and they open up to you as a nurse. The minute that you have that uniform on, people really tell you all sorts! It all comes out! And you have got to have that front because people need to trust you.” (FG10-2 2nd year student)

The students identified the uniform as a symbol of trust and professionalism and that patients could therefore recognise the nurse as a person with whom they should establish a relationship with. A relationship that is professional, and not personal. As an enduring symbol of nursing, students used the uniform to gain the confidence, trust and respect of the patients. Despite their lack of experience as a nurse, even first year students expressed their reliance on the uniform to enable them to be seen as a part of the profession.

“I can’t wait until we get our uniforms and go out onto the wards, that is when we will really feel like real nurses!” (FG8-1 1st year student)

The association between looking like a nurse and feeling like a nurse was evident. However, the absence of a uniform (among Mental Health and Learning Disabilities students) did not minimise the importance of looking the part of being a professional that can be observed through the nature of the nurse-patient relationship.

“We don’t get the uniform that other nurses do but, if you do mental health nursing you are not necessarily going to be ‘talking in tongues’ all the time, trying to say big words because if you are talking to someone who doesn’t understand that, you will probably just kind of use slang words, or like chill out, just have a chat with them. And even though it might not look or sound professional to an onlooker, that is still professionalism because you are

supporting the person you are there to care for in the way that is meant for them.” (KU1-1 2nd year student)

Some students made references to gender and sexual stereotypes that have been associated with the nurse’s uniform. The concern about sexualised images of nurses were acknowledged, but largely not referenced; being considered to be inconsistent with their own view of nursing.

“A lot of people have asked me about the uniform... and I am not going to go into detail about that here (laughs). That was odd, that was one of the things that struck me was like these stereotypes of nurses that people have, they place assumptions upon you, that was something that I found quite surprising.” (FG1-3 1st year student).

One male student referenced a gender stereotype about wearing the uniform that highlighted the large gender division in nursing, in favour of female nurses.

“I have had a lot of comments from my mates about being a nurse. When they saw me in my uniform for the first time I got a lot of stick, as you can imagine. It was all just banter but you are always aware that when you’ve got the uniform on, you stand out from all the others, you know? Being a man in a woman’s world.” (KI2-3 3rd year student)

The image of the nurse’s uniform being a woman’s dress (rather than a male nurse’s tunic) not only reflects the female dominated gender split of the profession but was also identified as a symbol of the health service as a whole. Nurses being the ‘face’ of the organisation elevated the nurse’s uniform as a powerful symbol. This was noticeable when students discussed how they felt that nurses were being used as scapegoats for the failings of the NHS.

FG1-3- *“We get the full force of the blame because we are, when you think of the NHS your immediate thought is that blue uniform...”*

FG1-6 *“Or the white uniform...”*

FG1-3 *“Or the white uniform (laughs). I never think of... when I think of the NHS, I never think of the white coats, and I think again, it refers back to the fact that nurses are the ever-present force on the wards. The doctors all come around for[ward] rounds, obviously, but if you need anything in that 24 hours when you are in that bed, the nurse is your first port of call. If you ring that buzzer it’s a nurse that’s going to come to you.”* (1st year students)

Overall, the nurse’s uniform was described as a positive image of the profession. It served the purpose of: establishing professional relationships; promoting a sense of trust in the patient; created a sense of belonging in the students; and provides a visual representation of the organisation. Despite its use becoming more limited in practice, students readily identified it as being an essential part of the profession’s identity.

A powerful representation of professional nursing was the students’ description of how nurses make time for patients through simple acts. Providing a cup of tea to a patient was referenced on several occasions as an exemplar of how a good nurse would take time out of a busy day to give a patient personal attention. The act itself produced a recognisable visual image of humanity amidst a sometimes chaotic, and impersonal situation. The origin of this idea was possibly from wider sources but had been utilised by the RCN in a recruitment video called “This is nursing”. Students at both sites reported having been shown this video at the beginning of their programme. In the video, a variety of situations, in which nurses are going about their work, are shown from the point of view of a patient in a hospital. During a clip

(lasting approximately 1 second), a nurse places a cup of tea on the patient's bedside table. Despite this momentary segment being placed in a video in which nurses are also seen attending emergencies, and dealing with other demanding situations, this act seemed to have resonated with the students the most.

FG2-1- *"I really like that moment when this lady was given a cup of tea and I was thinking 'yeah that is what this role is sometimes about!' just even this..."*

FG2-2 *"...the basic..."*

FG2-1- *"...the basic cup of tea, can change everything, a calm perspective for the patient. And so, I am thinking... the whole message coming out of this movie, I really liked that everyone was trying to be looking positive and trying to give people hope, that you can hold on to something on a really bad day in the hospital."* (FG 2 1st year students)

The possibility for a nurse to make time to give the patient a cup of tea is representative of the way that students perceived the potential- that being busy- has on the nurse's ability to provide comfort for their patients. As a visual symbol of demonstrating care and compassion, the cup of tea is representative of many other simple acts that students lamented as being lost, at times when there is a high demand on their time.

"There isn't time to do the little things for the patients" (KU7-1 2nd year student)

"Maybe, back in the old days, there was time to spend with the patients...most of the time we are just too busy now. It's sad really." (KI 9-2 3rd year student)

Furthermore, it was the loss of time to pay attention to the ‘little things’ that was used as an example of how nurses might be perceived as uncaring.

“So, I think that it is not that nurses have forgotten how to care, I think that they don't have the time to care. They would like to sit down and talk and have a cup of tea and things like that, with the patients, but they don't have the time. If you are looking after 2 bays with 14 people and you are just one person, you are not going to care or tend to the needs for all of them.” (FG9-2 2nd year student)

An extension of this visual imagery of care and compassion was also given as an exemplar of how nurses gain deeper understandings of their patients. Knowing seemingly simple facts about a patient, was considered to be the essence of professional nursing.

“It's very intimate. Its things like, after a couple of days on the ward you know how a patient takes their tea, it's that really personal thing that you get to know about patients.” (FG1-4 1st year student).

Visual imagery of nurses seemed to say more about how the students viewed the nursing profession than the acts themselves. Wearing a uniform or making a patient a cup of tea, might be seen to have no direct benefit to the patient’s treatment or be essential requirements for effective medical therapy. However, these symbols were utilised by students to represent how they view the role of the nurse and how they perceived the importance of performing these acts as means by which trust, care and compassion could be communicated to the patient.

8.3 Overview of Macrosocial processes

Students develop a perception of professional nurses as both highly regulated and, simultaneously, fluid and flexible. They recognise the need to provide care that is individualised to the specific needs of the patients. This arises from the notion that patients each have unique expectations of the nurses who care for them, and that individual patient needs must be attended to. However, the autonomy required by nurses to individualise care and to attend to specific needs of patients, is often found to be in conflict with the notion of regulated practice. The students in this study viewed the NMC code as a statement of boundaries for practice, and also as a baseline for competent practice. In this respect, the NMC code lays out the minimum and maximum extents within which they perceive professional practice to exist. Although the students felt that the NMC Code implied that certain traits are desirable in professional nurses, they did not feel that it provided enough specific guidance about how the nurse should practice. Like the Mesosocial analysis of university education, students felt that the NMC Code's primary aim is to inform nurses about what *not* to do. The student's view of professional regulation is therefore a product of a wider goal; to prevent nurses from harming their patients. This view of the NMC Code is their interpretation of it and bears only a limited relationship to reality.

Providing individualised care and meeting the patient's expectations are valued highly by students; they aspire to nurses whose practice allows time for them to occur. However, the nature of professional regulation is perceived to be a significant barrier to individualised care. Autonomy to provide care in a fluid, individualised

and sensitive manner is viewed as being in conflict with highly regulated practice
(Table 8-3)

	Professional regulation	Individualised practice
Positive	<ul style="list-style-type: none"> - Sets a minimum standard - Ensures patient safety. - Framework for identifying bad practice. 	<ul style="list-style-type: none"> - Nurse acts autonomously to decide patient priorities. - Nurse is presented as human and personable. - Time allowed for attending to patients' individual needs.
Negative	<ul style="list-style-type: none"> - Imposes limitations on nurse-patient relationships - Limited framework for the totality of nursing practice. 	<ul style="list-style-type: none"> - No specific frame of reference; is not taught. - Uncertain boundaries between professional and personal behaviours.

Table 8-3- Students view of the conflicts between Regulation and Individualised practice

For students, being regulated is an essential component of being a professional nurse. However, professionally regulated behaviour is viewed differently to professionalism, Professionalism is the term that students used to describe the fluidity and autonomy that professional nurses exhibit as they move between formal, regulated behaviour, and informal, individualised behaviour. Notwithstanding the

distinction that students place between regulation and individualised practice, they recognise that the NMC code implicitly defines some expectations on the nurse's personal behaviours.

The professional regulation of nurses is perceived to provide a framework that allows students to recognise unprofessional practice from the earliest stages of their nurse education. It also establishes a minimum level of competence against which students can compare their own practice, and that of the nurses that they work with. The enforcement of this framework is underpinned by the threat of removal from the professional register, or failure to successfully pass the practice elements of the programme. Therefore, adherence to professional regulations comes from both a sense of duty and as a means of remaining on the professional register. When looking for other reasons that the nursing profession regulates the behaviours of nurses in this way, it is clear that students feel the need for the profession to respond to wider criticism about failings in the health service. The requirement for the profession to identify and remove practitioners who fail to meet a minimum accepted standard, is understood by students as one way to address negative perceptions of nurses by the general public. The influence of negative criticisms on the nursing profession is clearly stated by these students, as motives for this heightened scrutiny of nurses. Furthermore, the political response to public reports into failing care standards is felt to be counterproductive. The motivation behind initiatives from the Department of Health, like the 6C's, are questioned by the students. The perception that their own profession is not defending them from criticism- and even exacerbating it- leads the students to view their own profession as passive and powerless when met with questions about their integrity as public servants.

Imagery of nurses both past and present, shape the students' perception of the nursing profession. They recognise that nursing is bound to its history and that visual images of nursing's past are still pervasive. These images are learned to be anachronistic, as the students progress through the programme. Idealised and historical imagery of nurse- which are viewed as positive at the beginning of the programme- are replaced by more contemporary imaginings of nurses as modern professionals, that undertake advanced roles in practice. Furthermore, the historical images of the nursing profession are considered to be unhelpful and inhibiting; leading to the public's mismatch of their perception of what nurses should be like, and how they actually are. A conflict between historical and contemporary nursing imagery is recognised by students as being problematic (Table 8-4). The incompatibility between traditional and modern nursing identities results in students struggling to establish a consistent identity, that can reconcile these two contrasting versions of the nursing profession.

The societal imagination of nursing's identity- being strongly associated with visual images of a nurse's uniform- are early influencers of students' emerging professional identity. These macrosocial influences direct students towards practice that is based upon meeting social expectations. However, the realities of practice that are experienced by students are found to prevent the adoption of the traditional archetype. As such, students are caught between the competing identities that are bound to past, and the contemporary worlds of nursing.

	Historical/tradition image	Contemporary image
Positive	<ul style="list-style-type: none"> - Universally recognisable identity. - Positive image associated with the nurse. 	<ul style="list-style-type: none"> - Fit for modern healthcare - Highly educated - Autonomous - Evidence-based
Negative	<ul style="list-style-type: none"> - Anachronistic - Implies uniformity and regulation. - Less education required. - Limited evidence base. 	<ul style="list-style-type: none"> - Incompatible with societal expectations. - Exposes nursing to questions about commitment ('too clever to care')

Table 8-4- Student's view of the conflict between traditional and modern nursing imagery

8.4 Summary of the findings

The analysis revealed 6 thematic categories which have been presented as constructs of a theory that describe the formation of professional identity in nursing:

- 1) Perceiving self as a nurse
- 2) Presenting and managing self
- 3) Acquiring professional knowledge
- 4) Connecting with the 'real world' of practice
- 5) Regulation of nursing practice
- 6) Imagining nursing

Within each of these constructs, the findings reveal how students understand the self-concept of the nurse, and perceptions of the function and image of the nursing profession. The construction of professional identity in nursing has been revealed to be dependent on a variety of influences from which those who enter the undergraduate pre-registration nurse education develop meaning about being a professional nurse, and about being a member of the nursing profession. The analysis has shown how students describe identity of professional nurses and the identity of the nursing profession as separate concepts. Professional identity is therefore understood to be more than an overarching concept that is the product of students' socialisation. Instead, professional identity is revealed to be comprised of identity work that operates at both an individual, and at a professional level. These two identities must be negotiated and managed as students make the transition from lay person to professional. Conflicts and inconsistencies have been described between (and within) the individual and profession identities.

The analysis has highlighted the importance that students place upon managing the authentic self when faced with such conflicting expectations by public, patients and profession. This process is required for demonstrating positive behaviours to patients, and for fitting in with professional colleagues. The relationship between the professional nurse and the nursing profession has been revealed to be problematic; the former being a product of the self-concept, the latter being subject to social and political influence, that enforce rigid boundaries of professional behaviour. The students model their behaviour on professional nurses who are able to autonomously negotiate rigid professional boundaries and overcome the perceived disparity between regulation and individualised interpersonal relationships. Professionalism in nursing was perceived as going beyond the minimum requirements of professional regulation to satisfy the expectations of patients. Students identify positive aspects of the nurse's identity as their ability to manage the triad of patient expectations, professional behaviour, and emotionally connecting. The professional identity of the nurse is therefore revealed as being in a state of interaction with the nursing profession's identity, but separate from it.

The lay person enters the profession with pre-existing ideas about nursing that are derived from personal insights and social constructions of the nursing profession. The self-concept of the student nurse forms the foundations of an individual professional identity. This identity is then refined according to the experiences faced in the 'real world' of practice; which is often in contrast to the professional world that is presented to the student by educators in the university. Out of these

conflicting notions of the nursing profession, the student learns to manage their individual professional identity so that authenticity with their self-concept can be retained as far as possible.

The conflicts between expectation and reality, that are experienced by students in practice, arise from macrosocial processes, in which societal images of nursing are counterbalanced against the individual's concrete experiences. The historical image of nursing was described as problematic to students as they entered the nursing profession. The nursing profession itself, appears to reinforce an anachronistic image of nursing as a low status and passive occupation, rather than presenting itself as a modern, and high-status profession. The role of the public media also appears to be an important factor in undermining nursing's contemporary identity, particularly with regards to degree-level nurse education. The ongoing image of nurses being a part of 'the caring profession' subsumes a range of social practices that students described as being challenging. For example: the teaching of care and compassion in the university; the professions muted response to public criticism that students were 'too clever to care'; and the mandate of the 6C's by the Chief nurse of Great Britain. These were all used as examples of nursing's incompatible relationship with its past. The symbolism associated with the nursing profession still has a profound influence on the behaviours of the students. The nurse's uniform is a metaphor for similarity and conformity, as well as providing a professional barrier between individual and profession.

These six core processes are revealed to be interrelated. Each operating at different levels of analysis (micro, meso, macro) but often overlapping each other. The discussion that emerges from these findings can now be advanced by coalescing the themes- by taking away the arbitrariness of categorising them into levels of social practice- and by exploring how these findings illuminate our understanding of professional identity. Four resultant constructs of professional identity are evident here. These are:

- 1) Nursing as a reflection of authentic self,
- 2) The modern professional,
- 3) Nursing as bound to its past,
- 4) The caring profession.

In the following chapter, these constructs are discussed by presenting the central ideas behind them, revealing how professional identity is constructed by the student nurses in this study.

9 Discussion

This study addresses the question of how pre-registration undergraduate student nurses construct their sense of professional identity. To achieve this aim, four objectives have structured the investigation and framed the analysis. These objectives were to:

- Gain an understanding of how students perceive the role of the nurse at the beginning and throughout the pre-registration programme.
- Identify any changes to student's sense of professional identity as they progress through the programme.
- Explore student's narratives about the formative experiences, and the individual and social factors that influence the process of becoming a professional nurse.
- Provide an explanation of the process of professional identity formation amongst pre-registration student nurses.

These objectives sought to understand, firstly, how students perceive professional nursing (i.e. what is their frame of reference for professional identity formation?); and secondly, from where this professional identity emerges?

In this chapter, the findings are summarised and discussed in the context of existing literature. An explanation of the way that these student nurses described their professional identity, and the factors influencing that understanding of nursing's professional identity, will be provided.

In the summary of the findings (section 8.4) it was identified that four conceptual themes have emerged.

- 1) Nursing as a reflection of authentic self,
- 2) The modern professional,
- 3) Nursing as bound to its past,
- 4) The caring profession.

The overriding ideas that can be referenced back to the aims of this study and presented here as the central tenets of this thesis, will be developed. The conclusions drawn from the analysis of the data, and reflection on the findings of that analysis, describe how professional identity has been defined, how identities are negotiated, and from where professional identity originates. The key ideas of the analysis can be outlined thus:

- 1) Students define a duality within the concept of professional identity.
- 2) Identities are managed and re-orientated during the programme.
- 3) Professional identity is a constructed out of a conflict between historical and contemporary nursing discourses.

The following sections of the discussion address these ideas. The first section of this chapter discusses how the concept of professional identity of nursing is re-defined by these students. This discussion reveals the duality of professional identity; being comprised of Individual and Professional Role identities. This section also addresses influences and conflicts, that are managed by students in the development of their professional identity. The interaction between the self-concept, Individual professional Identity, and the Professional Role Identity will be discussed. Table 9-1

outlines the structure of this chapter and shows the relationship between the concepts emerging from the data and the ideas being presented. The second section discusses the ways in which the professional identity of nursing is socially constructed, and the impact of public discourse on the development of professional identity among these students. Here, the thesis that the professional identity of nursing is a product of social practices that are imposed upon students- before and during the undergraduate pre-registration programme- will be presented.

Professional Identity of Nursing (Section 9.1)	Individual Professional Identity (Section 9.1.1)	Nursing as a reflection of the authentic self (Section 9.1.1.1)	Perceiving self as a nurse
			Perceptions of friends and family
			Intrinsic motivations
			Managing emotions
			Personal transformation
	Professional Role Identity (Section 9.1.2)	The modern professional (Section 9.1.1.2)	Being academic/part of an academic profession
			Professional regulation
			Acting like a professional
			Being a part of the ‘new generation’ of nurses
		Nursing as being bound to its past (Section 9.1.2.1)	Imagining nursing
			Experiencing public media criticism
		The caring profession (Section 9.1.2.2)	Forming relationships with patients
			Political regulation
			Identifying role models

Table 9-1- Defining professional identity

9.1 (Re)defining professional identity

Analysis of the findings reveal that students do not describe a single unifying concept of professional identity for nursing, but that the identities of the professional nurse, and the identity of the nursing profession, are conceptually distinct. Therefore, the concept of professional identity described by the students in this study, is defined as being comprised of Individual Professional Identity (IPI) and Professional Role Identity (PRI).

The students were asked questions that sought to reveal their perspectives on nursing's professional identity and to uncover potential influencing factors from which these perceptions were created. Firstly, they spoke at length about the identity of nurses as individuals; as members of a wider professional body. Secondly, they described a professional identity that defines the nursing profession in terms of its role, social function and status. Existing literature describes professional identity as being the relationship between an individual and the professional group that they belong to. Adams et al. (2006a), for example, define professional identity as a form of social identity in which the group's interactions in the workplace are used to compare and differentiate themselves from other professional groups, thereby creating a sense of unity and similarity among the group members. This perception of professional identity draws on the social identity theory posited by Tajfel and Turner (1986) that states that the behaviours of the members of one group towards another are dependent on the strength and relevance of the group members social identity. Here an interrelationship between the individual and the group is suggested

in which strength and cohesion are required by the individuals. From the perspective of social identity theory, the student nurse would see themselves as a part of the professional group of nursing, and not distinct from it. However, this view only partly corresponds to the perspectives of the students in the current study. Despite their strong association with nursing's espoused aims and objectives at the early stages of the undergraduate programme, they also recognised that they were separated from the professional group; in part due to their dual identity as undergraduate students, and also as nurses. Previous research by Clements et al. (2016) described how student nurses felt a lack of acceptance by qualified staff due to their status as undergraduate students. Being perceived as outside of the professional group was suggested to be a negative influence on their commitment to the profession. The current study did not reveal such an impact on commitment to the profession, but a discrepancy between being a nurse and being part of the nursing profession was observed. Whilst students described an association between their own values and motivations and those of the profession, they also were aware of a disconnect between them. This disconnect is evident from their descriptions of themselves as being part of a 'new generation' of nurses who were charged with the responsibility to transform and modernise nursing care, and to improve existing practices. Therefore, students describe being caught between the competing expectations of conforming to the norms of the profession, whilst also taking on the responsibility to modernise it.

The existing literature commonly defines professional identity as being a product of the socialisation process (Fitzpatrick 1996, Cohen 1981, Curtis 2012), whereby a student enters the group and is inculcated with the group's professional identity.

Institutions have also been associated with a distribution of social norms through the behaviours, rules, uniform and other symbolic artefacts such as hospital badges, that are identified with those institutions (Bradbury 1990, Maben 2008, Maben et al. 2007). When nurse education was undertaken in hospital schools of nursing, the identity of nurses trained in a specific hospital were bound to the identity of the institution (i.e. a “Tommy’s nurse” for St Thomas’s hospital, London; or a “Jimmy’s nurse” for St James’ hospital in Leeds etc). Modern nurse education takes place in Universities, with practice placements being undertaken in one or more partner NHS Trusts. The students in this study did not identify themselves with a hospital or NHS Trust during their discussions. Neither did they describe having observed specific behaviours or identities of the nurses based on the institution. This study suggests that a transformation of identity has occurred among the student population whereby their identity as nurses and their identity as being a part of the wider nursing profession has replaced an identity that is based entirely on a hospital or education institution. Furthermore, it is contended that institutional identity is no longer embedded in the hospital, but instead, the students derive their professional identity from the profession as a whole.

9.1.1 Individual Professional Identity

When the students in this study referred to themselves or described their individual motives for wanting to become a nurse, they provided an insight into how they (as an individual) perceived themselves in the context of their chosen profession. Students gave many examples of why they see themselves as being the ‘right type of person’ to be a nurse. These reflective narratives demonstrated how the students’ self-concept is revealed when placed in the context of their chosen profession. The analysis of these narratives yields two interrelated yet discreet concepts:

- 1) Self-concept- the way that they see themselves.
- 2) Individual Professional Identity- the way that they see professional nurses, or the way that they envisage their future-selves as professional nurses.

Individual Professional Identity (IPI) differs from self-concept as it is a contextualised form of the self. In Carl Rogers’ definition of self-concept, there are three components:

- 1) An individual’s view of themselves;
- 2) The value that individuals place on themselves;
- 3) Their idealised self

(Rogers 1959).

In this respect, self-concept is focused on the individual and their self-image; it exists without a specific context or external referents. However, Turner and Oakes (1994) also recognised that self-awareness might only become available to an individual via reflecting on oneself in comparison to others. And that *self-categorisation* establishes how the individual perceives themselves by making direct reference (and

gaining feedback from) others. The students in this study made frequent comparisons between themselves and others. At the beginning of the programme, the students compare themselves against a schema of how they perceive professional nurses to be. This schema is based upon the common perceptions of nurses that are available via a public discourse of nursing. Students who have some prior insight into the profession (through previous care work or from family members) appear to have more a detailed schema with which to make their comparisons. Those students without personal insight into the profession make more generalised and abstract statements about nurses. Towards the later stages of the programme, students demonstrated self-categorisation by referring to themselves in comparison to their chosen role-models. Although it should be noted that these role-models were selected on the basis of the similarity of the personal values and attributes that were shared between student and role-model. Attributes such as, compassion, organisation, leadership and resilience are typical of the aspects of the role-model's identity that students align themselves to. In the study by Shakespeare and Webb (2008), the interaction between nurse and mentor offered an alternative view. In that study, mentors evaluated the professional identity of students with reference to their enthusiasm, commitment and confidence. It might therefore be concluded that both student and nurse evaluate each other with reference to certain anticipated behaviours.

New entrants and more experienced students identify a schema for self-categorisation; a schema that reveals a perception of professional identity that is exhibited by individual nurses. This study suggests that self-concept is distinct from IPI but interacts with it (Figure 9-1). IPI is representative of the student's perception

of how nurses are, and also provides them with a schema from which they derive their own sense of belonging and self-worth.

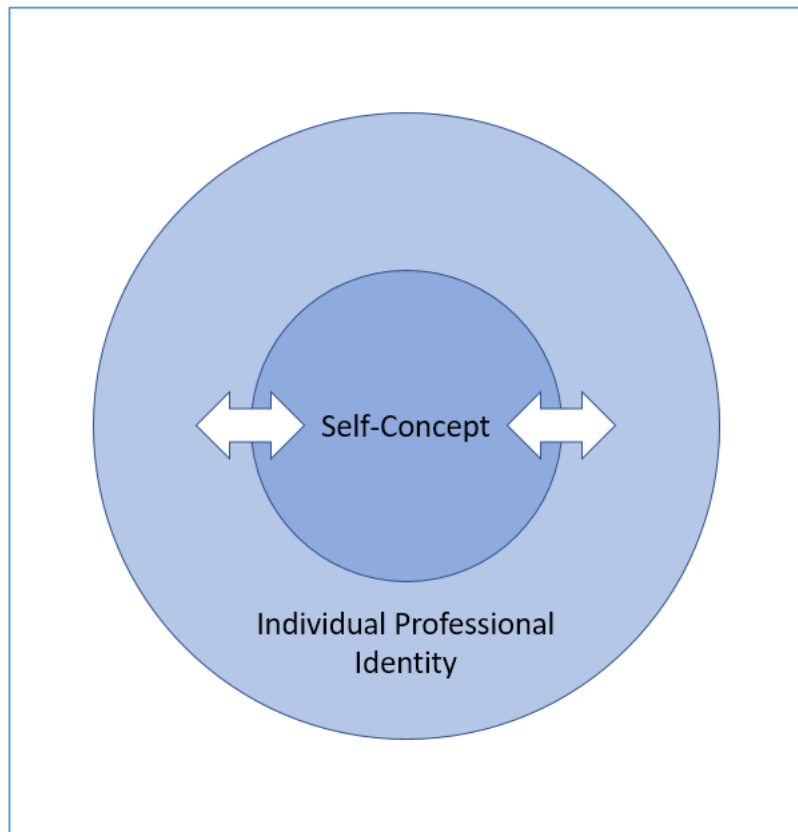


Figure 9-1 Self-Concept and IPI

Students made reference to their own personal attributes as a basis for why they felt that they were right for the profession. Where the personal and professional identities meet, the self is placed into the context of the profession. The relationship between self-concept and IPI expresses the degree of authenticity that these students perceived to have with being a professional nurse (represented by the arrows in Figure 9-1). The findings from this study suggests that:

- 1) students choose to enter the nursing profession based upon their self-categorisation as someone in possession of the attributes required for the profession.
- 2) Self-concept establishes a reference point from which Individual Professional

Identity is constructed.

3) Individual Professional Identity is a version of the student's self-concept that has been contextualised in the professional domain.

The IPI revealed through the narratives describe the students' perspectives of professional nurses as they expected them to be; it is based upon a schema that was constructed from their existing beliefs about nurses, and hence, the type of nurse that they aimed to become. Examples of how students' self-concept might construct Individual Professional Identity are given in (Table 9-2).

Self-concept	Individual Professional Identity
"I am a caring person"	"Nurses are caring people"
"I think of myself as an honest and genuine person"	"Nurses give a lot of themselves to their patients"
"I like to talk to people"	"Nurses are good communicators"
"I am quite an organised person"	"Nurses have to be able to plan their work well"

Table 9-2 Contextualising self-concept as IPI

These quotations are examples of how personal attributes are contextualised into the professional domain. A high degree of authenticity between self and profession is evident in these statements. These are typical ways in which the students presented themselves as being intrinsically 'right' for the role of professional nurse.

9.1.1.1 Nursing as a reflection of authentic self

The findings from this study suggest that the starting point for the process of professional identity development occurs before the student begins the undergraduate programme. How long before, is subject to some variation and depends largely upon prior experience and insight of nursing. Evidence from this study suggests that a student who comes from a family of nurses is likely to have built up the foundations of a professional identity through their interactions with those who have first-hand experience of nursing. These students described conversations with their family, friends, school teachers etc, during the contemplation stage of entry. Confirmation of their suitability for the profession was received from these significant peers. Students clearly described the importance of certain personality traits as essential pre-requisites for entry. These traits were most often described as being of a caring disposition, being able to cope with long hours on duty, and having a sense of duty to others.

The students reveal a process in which the individual's self-concept is compared with a schema of the person that they believe a nurse to be. It has previously been suggested that it is from this reflection on the self-concept that initiates the journey from lay-person to professional nurse (Larson et al. 2013, Mazhindu et al. 2016). Certainly, it is noted that entry to the profession followed a period of reflection in which the student revealed aspects of their self-concept by scrutinising their own inherent motivations and goals. Self-concept encompasses one's self-image and self-esteem; the former being the way that we imagine ourselves, the latter a more abstract perception of our sense of value (Augusto Landa et al. 2009). Research that

explores self-concept and professional identity commonly refer to professional self-concept; an amalgamation of the two (c.f. Arthur et al. 1999, Cowin et al. 2008, Hensel and Stoelting-Gettelfinger 2011, Hoeve et al. 2014). However, this study suggests that the separation of self-concept and professional self-concept provides a more meaningful way with which to understand student nurses as individuals, and as neophyte nurses. The self-concept is a construct of all aspects of the student's life, whereas the professional self-concept is only a part of that. The students did not always refer to themselves as nurses but often made statements about themselves as individuals outside of nursing. Furthermore, students placed a greater importance on the need to keep the social-self and the professional-self separate as they progressed through the programme.

Regardless of prior insight into the profession, it is likely that students would have some ideas about the nursing profession, just through public awareness alone. A student entering the profession, who has been employed in another unrelated occupation (or has not previously contemplated nursing as a possible career) may still have been influenced by other sources (such as recruitment materials, TV documentaries and drama, and fictional literature). Whilst some of the students in this study acknowledged that they knew very little about nursing when they began their nurse education, they clearly described how they had known enough upon which to base their decision to choose nursing over other career paths. The nursing profession was a part of their awareness of the roles that need to be fulfilled in our society; they often described nursing in terms of its service to society, fulfilling a need to help all those who need it. It is from this awareness that, as members of society, they were able to imagine nursing in one form or another; to understand its

function, and to have at least some idea about its configuration. From this, it can be concluded that public discourse of nursing has a large impact on the students entering the profession; be it from direct experience or through indirect exposure to a public discourse.

Their perception of the nursing profession is derived from macro and microsocial influences even before concrete experience is acquired. The nursing profession is therefore 'out there' as a social construct and shapes the understanding of what nursing is, what it stands for and who is best suited to it. Widely accepted imagery of nurses and the taken-for-granted assumptions made about nurses- as a certain type of person- shapes the students' notions about the qualities that make a 'good nurse'. This conclusion contradicts the notion that nurse education is solely responsible for the development of professional identity in student nurses; an assumption that is commonly adopted in much of the existing literature (McKendry et al. 2012, Padilha and Nelson 2011, Sabanciogullari and Dogan 2014, Serra 2008, ten Hoeve et al. 2014, Thomas et al. 2015, Toman and Thifault 2012). The formation of IPI is therefore a predisposition rather than a learned behaviour. It arises from existing knowledge about professional nurses, that are passed to the entrant via micro and macrosocial influences (Table 9-3).

Social influences constructing Individual Professional Identity (IPI) (examples from the findings)	
Microsocial	Insight from: <ul style="list-style-type: none"> - Family members and friends in the nursing profession - Personal experience of being cared for by a nurse
Macrosocial	Insight from: <ul style="list-style-type: none"> - School careers advice - Recruitment advertisements - TV documentary and drama - Autobiographical literature

Table 9-3 Social influences of IPI described by the students

Nurses who act authentically, and present their true selves to their patients, are regarded as positive exemplars of the nursing profession by student nurses and potential recruits. Managing professional distance with patients in a way that does not compromise the expression of authentic caring, appears to be a necessary aspect of nursing's identity that students aspired to. This mode of behaviour was not described as being a means with which to appear caring where genuine caring was absent. On the contrary, it is suggested that students manage such actions when it was felt to be beneficial to the patients or themselves. For example, the student describing her experience of speaking to a patient after another patient in the same bay had died (page 46), shows how managing emotions and maintaining professional

relationships with patients require a complex balance between authenticity and formality. Not wishing to 'break down' in front of patients, to reassure them that the nurse is still capable of functioning effectively, had to be balanced with an outward expression that did not imply a lack of compassion or of emotional dis-engagement. Wherever possible, the students in this study emphasised the salience of not only expressing care and compassion, but also that these traits were true representations of their authentic self; that they genuinely cared and were not pretending as if they did.

The theories of *emotional labour* and *surface acting* (Hochschild 1983) and *Face-work* (Goffman 1969), offer some explanation about how the students manage their outward presentation to their patients and their peers. Surface acting is the outward presentation by an individual to demonstrate desirable attributes and to appear concerned for the wellbeing of others (Delgado et al. 2017, McQueen 2004). Deliberate repression of certain emotions (whilst emphasising others) is managed by the individual according to the circumstances (Huynh et al. 2008, Smith 2012, Smith and Gray 2001, Truc et al. 2009). This idea was interpreted into the context of nursing by Pam Smith (2012) by identifying the ways in which nurses express an image of care and compassion which may (or may not) be genuine and authentic. Furthermore, Smith contends that such active behaviour comes at great emotional labour to the nurse. The students in this study did not describe such acting as being a cause of emotional stress; rather, it was defined as an expected part of the nurse's repertoire. The argument that presenting oneself as being caring and compassionate- and that these expressions are authentic- is supported by the students in this study. However, the students also reported that, most often the expressions of caring and

compassion are authentic and that it is the outward appearance of distance, disengagement and formality that are the affectations; designed to repress their true feelings to protect their patients. Goffman's *facework* offers a similar interpretation about the act of presenting oneself in a given manner, according to the situation, to be perceived by others in a certain light (Goffman 1969). In the context of this study, such presentations were also understood to be functions of identity work; as a product of, and maintenance of, the students' professional identity. This authenticity between themselves as individuals and themselves as nurses, forms the baseline (or reference point) from which students self-categorise, and evaluate other nurses. The desire to be authentic; to maintain the essential components of their own personality in their work; to maintain consistent self-concept throughout their nurse education; and to give themselves to their patients, provides an outline for the students' Individual Professional Identity.

Students did not describe a transformation in themselves as individuals. Instead, they reveal that they attempted to maintain their authentic self as much, and for as long as is possible. Rather than becoming a changed person, the students described how they developed new ways of managing their Individual Professional Identity in ways in which their professional work becomes the embodiment of their authentic self. The literature on professional socialisation often assumes a degree of transformation (Condon and Sharts-Hopko 2010, Cook et al. 2003, Duquette 2004, Latimer 2005, Ware 2008). Whether that transformation occurs at the level of the self-concept, or occurs at a behavioural level, is rarely stated. However, becoming a professional is revealed in this study as a product of exerting the self-concept in a new professional context (the IPI). This concurs with students' ideas about professionalism as being

more than simply adhering to the professional norms and regulations; it is the managed exposition and imprinting of individual values upon the daily activities undertaken in nursing practice. Therefore, managing the authentic self is suggested to be a foundational process in the student nurses' Individual Professional Identity.

9.1.1.2 The Modern professional

Students made frequent reference to nurses now having an influencing role in modern healthcare. This reveals how these students perceive nurses to be a part of a modern profession, that requires skills not seen as necessary in the past. This study shows that becoming an all-graduate profession has had a profound influence on these student's professional identity. The students perceive that a transformation has occurred in the nursing profession, with them now being mandated to affect positive change where standards of care are perceived to be falling. Practicing autonomously and acting as a change agent are aspects of the individual professional identity that students defined as different from nurses entering the profession before them. The recognition that modern nurses are different from their predecessors appears to originate from recruitment advertisements, professional communications (e.g. the "This is Nursing" video (RCN 2013)), and from experience of working with their identified role-models.

The students at the beginning of the undergraduate programme expressed a limitation to the extent to which they felt able to vary or introduce novelty to practice. The students in the first year preferred to adhere rigidly to the attitudes and behaviours based upon decontextualized rules prescribed to them in the NMC Code. In her doctoral study exploring the development of expert practice, Patricia Benner described the earliest phase of learning in clinical practice as that of being a 'Novice' (Benner 1984). In the novice phase, pre-registration student nurses lack concrete experience from which to base their practice. To establish safe and competent practice, novices rely on rules to guide their decision-making. These rules are

context-free and provide generalised principles that novices can refer to (ibid). The current study supports this idea; first-year students made frequent references to the NMC Code as being the benchmark for their clinical practice and as a reference point with which they evaluated the behaviours of other nurses. The NMC Code is free of context as it is intended to provide guidance across the entire scope of nursing practice, wherever it may take place (NMC 2015). The acquisition of concrete experience through clinical practice placements, allow students to observe the ways in which abstract and context-free rules can be applied to novel patient scenarios (Benner 1984, Benner et al. 2009). It is from the observations of other experienced nurses that students learn the nuance of knowing where professional boundaries are, and how professional nurses define (and redefine) these boundaries when facing novel or unexpected situations. In their observations of their positive role-models, the students learned that the visible behaviours of nursing are simply the product of invisible professional knowledge that underpins practice and allows them to re-negotiate professional boundaries. In a study by Melia (1984), 40 informal interviews with students revealed how they learn to adapt their behaviours according to the two versions of nursing identity that are presented to them by the education institution, and by nurses in the clinical environment. Where there is conflict between the expectations placed on students by educators, and by nurses in practice, the student learns to 'fit in' as required. The findings of Melia's study are borne out by the current study, but a further dimension can be added to this understanding. At the beginning of the programme, where experience of clinical practice is limited, the desire to be seen as a 'good student' enforces an uncritical compliance with local practices. Furthermore, the absence of clinical experience that requires the student to rely on context-free rules to inform their decision-making, might leave them feeling

unequipped to challenge local practices. Students aspire to be able to act outside of rigid local practices and to choose how and when to adhere to prevailing social norms. Hence, when identifying role-models, students recognise the ability to practice autonomously as a key component of a nurse's professional identity that they wish to attain. The modern nursing profession is therefore identified as being free of behavioural restrictions that were associated with nursing in the past.

Edwards et al. (2010) contend that professional boundaries are socially constructed sites of practice and power-play. In this regard, professional roles, behaviours and scope of practice are defined externally to the profession and are enforced through the profession's own acceptance of those definitions. An autonomous practitioner is therefore able to define their own boundaries of practice or decide who is responsible for each role (Sims 2011). However, the degree to which professional nursing practice is truly autonomous, could be questioned. The extent to which deviation away from acceptable behavioural norms and role expectations, without transgressing professional boundaries, created some ambiguity among these students. Second and third-year students in this study identified role-models who demonstrated a freedom to practice in a way that is adapted to individual patient needs, and a confidence to explore alternative ways of practicing. Whereas, first year students described the 'good nurse' as being one whose practice rigidly and inflexibly adheres to 'the code'. From a qualitative analysis of student's journals. Waterkemper et al. (2014) found that the students' freedom to exercise autonomy and novelty in daily working practices, and a flexibility in their learning strategies, was a product of the pedagogical approach of the education institution. Where students were allowed to explore the limitations of practice and to understand the

means by which autonomy can result in creative and novel approaches to nursing care, nurse's work was reframed as less rigid (ibid). However, the university's presentation of professional nursing as being bound by strict regulation and disciplinary processes, was acknowledged as being inhibitory and ambiguous to the students. Being warned about 'what not to do' rather than emphasising specific positive behaviours in the classroom, shaped students' impressions of what professional nursing is (or is not) when on they were out on their clinical placements.

This study highlights a disconnect between the role of the professional nurse that is defined by educators and that which is observed by students in 'the real world'. The contradiction between being required to adhere to rigid and inflexible rules and being flexible and creative about the application of professional guidelines, is a point of conflict in the modern nurse's identity. For example, finding the distinction between being friendly and being distant; allowing visitors outside of normal visiting hours; knowing when hugging a distressed patient or relative might be appropriate, or not. It is suggested that the students reach the latter stages of their undergraduate programme with a perception that autonomous application of professional rules is central to modern nursing. Whereas, being inflexible and rigidly adhering to rules and behaviours is an aspect of neophyte student nurses' IPI.

9.1.2 Professional Role Identity

Distinct from the identity of individual nurses within the profession, the Professional Role Identity of nursing (PRI) is a broader definition about the relationship between the profession and society. Where IPI is focused on the identity of professional nurses, PRI is focused on the identity of the nursing profession; it defines nursing identity as a function of its social role. This study revealed continuities and discontinuities between the individual professional and the professional role identities. For example, there is a continuous theme that connects the individual nurse's identity as a caregiver, and the profession's role identity as the caring profession (Wilkinson 1998). Conversely, a discontinuity exists between the contemporary nurse as a university graduate, and the perception of the nursing's professional knowledge as subordinated by the hegemony of medical science (Playle 1995). As such, professionals are more than simply members of a profession; they are individuals with values and motivations that will (to some extent) align with those of the profession. However, where there are inconsistencies in the expectations of the values and attributes required of nurses, or differences of opinion about the role that nursing should fulfil in society, then the relationship between IPI and PRI becomes inconsistent.

As discussed in the Background (Chapter 2), an association between the function that nursing fulfils in society, and the way that the nursing profession is structured, is an ongoing part of nursing's history. As society's health needs change, then the structure of the profession changes, and with it, the identity of the nursing profession. For example, the widening scope of nursing roles (e.g. nurse prescribing,

the introduction of the surgical assistant role, and nurse-led services) was given by the students in this study as evidence of how the profession has gained a higher status in recent years. Comparisons between the limited role of the nurse in the past, to the more expansive range of roles available to nurses now, were made by students as a way of reinforcing the difference between the historical and the contemporary nursing identity. In a Danish study of nurses who undertook expanded roles, it was discovered that nurses worked hard to express themselves in a way that was still associated with their identity as nurses, and rejected notions of being physician's assistants (Piil et al. 2012). A New Zealand study offered a somewhat different conclusion; that nurses undertaking 'non-traditional' roles often rendered the relational components of their practice as invisible (Connor 2003). The fit between the traditional image of the nurse and the requirement for nurses to undertake roles that were previously outside of the scope of nursing practice, is therefore problematic to students. This study reveals that the nurse's professional role identity is contingent on the individual nurse's ability to manage competing expectations within their practice. Students in this study recognised the ambiguity of the competing expectations and placed a high value on the nurse's ability to move fluidly between them. The changes to nurse education, with the introduction of graduate entry, was cited by students as supporting evidence of nursing now being a modern profession with highly educated members.

Figure 9-2 shows how self-concept, Individual Professional Identity, and Professional Role Identity are interconnected. The bi-directional arrows between each layer of identity are representative of the mediating processes that connect them.

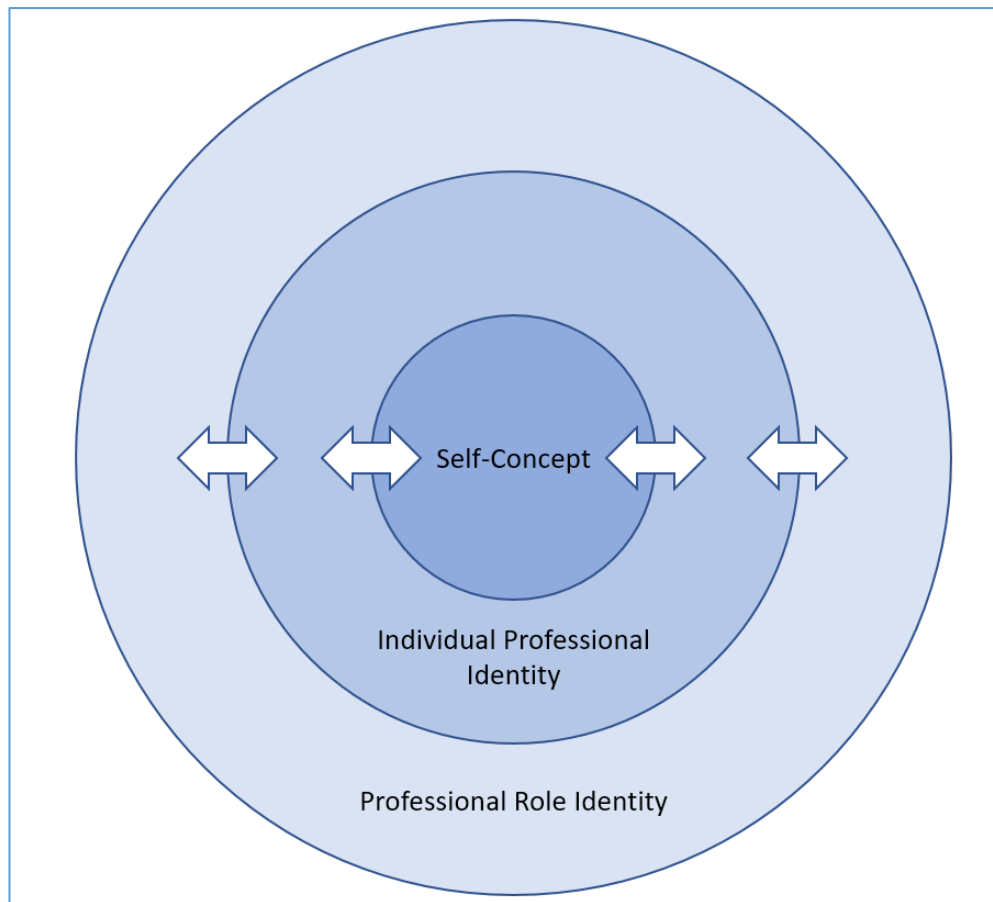


Figure 9-2 Relationship between Self-concept, IPI and PRI

It is suggested that the profession's identity is in a state of transition between the historical and the contemporary. Rather than a progressive move, this transition has been described as an identity crisis (Harmer 2010, Scholes 2008), in which nursing is perceived to have lost its caring function (Corbin 2008). Public media have seized upon a perceived 'crisis of caring' (Coward 2013), in which nurses are now 'too clever to care' for their patients as they attend to more technical tasks (Gill 2004). The passive response by the nursing profession to this public media criticism, and the lack of voice that nurses have in shaping public discourse (Gillett 2012, McMahon 2017), only serves to reinforce the disconnect between the past and

present status of nursing's identity. The NMC, through their standards for pre-registration nursing education (NMC 2010), has also been implicated in the reproduction of an anachronistic view of nursing's role function and identity by emphasising 'a caring professional attitude' as being the primary requirement for graduate nurses (Griffiths et al. 2012). Alternatively, the development of an all-graduate profession has been welcomed as a positive assertion of nursing's unique contribution to healthcare (McKenna et al. 2006); a perspective that was largely supported by the students in this study.

9.1.2.1 Being bound to the past

The students in this study describe nursing as being inextricably bound to its history. Their expectations of nurses being selfless, and duty bound to give care that frequently goes above and beyond that which is required, highlights a view of the professional that it is more than 'just a job'. Furthermore, it is perceived to be a role that the individual must be intrinsically 'right' for. This alludes to a pervasive notion that some people are born to be nurses, and that others are not (Brown and Humphreys 2002, Eley et al. 2012, Yam 2004).

The commitment to the nursing profession- demonstrated by these students- echoes the research by Clements et al. (2016) which found that students who readily associated themselves with the professional values gained a higher degree of self-esteem and self-worth from being members of the professional group. Similarly, students who describe nursing in terms of its vocational status, have been found to be highly committed to the profession (McCabe and Garavan 2008). Social identity theory (SIT) (Tajfel 1974, Tajfel and Turner 1986) provides a theoretical explanation of why students might desire to be aligned to the profession; how they may derive a sense of security and belonging by group membership; and why they might be more critical of those outside of the group. The students in the current study appeared to take pride in being a part of a group with an established identity that is built upon a long history of commitment and vocation. Furthermore, they made distinct comparisons between the values associated nursing and those of the medical profession; describing nurses as being primarily concerned with people and doctors being principally focused on disease and cure. Solidarity with their own group (the

in-group in SIT) was evident, even when faced with examples of poor practice. Students attempted to rationalise the cause of those bad behaviours as being a product of poor management and structural failings in the organisation, rather than being a consequence of the nurses 'not caring' for their patients. However, those outside of the profession (notably politicians, policy makers and hospital managers) were framed as the *out-group* and were not afforded the same attempts to rationalise behaviours that were felt to be the primary cause for the low care standards they observed. In a discourse analytical study of nursing student's narratives, Traynor and Buus (2016) suggested that the idealism and cynicism were forms of identity work that occurred to rationalise poor standards of care. They contended that students set out by identifying with the profession's ideals but lose this idealism over time. The basis of these ideals was that caring is an innate characteristic of some (but not all) nurses. Those nurses without the caring attribute were considered to have either lost it or become 'corrupted' in their professional practice. These findings are appealing as they postulate a rationale for the anxiety experienced by student nurses; that they fear losing their capacity to care. However, in the current study, despite this anxiety being expressed by some of the first-year students, it was evident that their anxieties were subsequently not realised. Students in the second and third years claimed to still possess their inherent capacity to care and that this had remained unchanged over the duration of the programme.

Across the three years of the programme, students distanced themselves from the traditional and historical views of the profession that they had described in the first year. Second and third year students realigned their views of nursing's identity to that of a more contemporary image of nurses as modern professionals. Kelly et al.

(2017) contended that students develop a strong association with nursing's identity by studying the history of nursing; and that it gives students a sense of belonging to a tradition. However, the current study reveals how students see nursing's history as not only irrelevant to contemporary practice but representative of practice that might be responsible for accounts of poor care standards. The preference to describe nursing in terms of leadership, management, technical knowledge, advanced communication skills and multidisciplinary working suggests that studying nursing history during the undergraduate programme (as Kelly et suggested), might not reinforce a coherent professional identity. Instead, compounding a conflict between the past and the present. Figure 9-3 suggests a model of how students re-orientate their identity over the duration of the undergraduate programme.

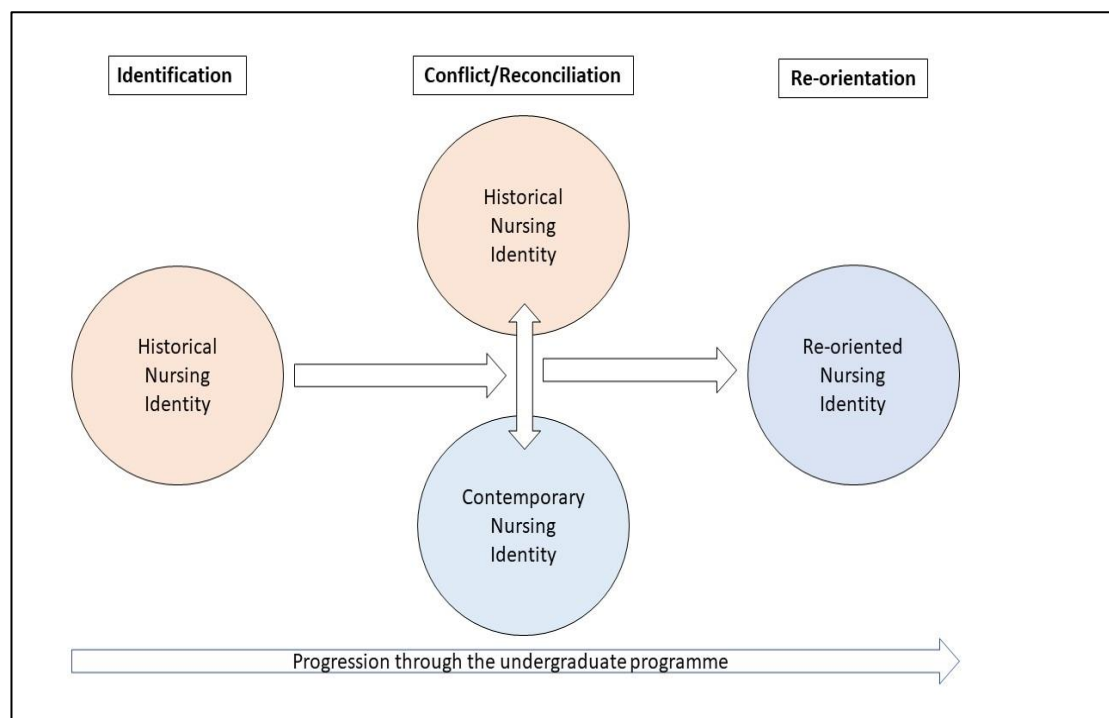


Figure 9-3 - Identity re-alignment through the programme

The process visualised here is that of Identity re-alignment. The students enter the programme with the same image of nursing's identity as that of the anyone outside of the profession who has had little or no direct insight into the profession. This study describes an *identification* phase, where an initial perspective is internalised from personal experience and social constructions of the nursing profession. Identification acts as a baseline from which the entrant to the programme makes reference to the professional world that they are entering, and the experiences that they are anticipating. These were strongly associated with hard work, virtue, emotional demands and ethical challenges. The students in this study usually based this early identification upon abstract conceptualisations of nursing from macrosocial influences, rather than tangible or experience-based insights.

A second phase of identity re-alignment occurred as a result of learning in practice and in the classroom. By the middle to late stages of the undergraduate programme, students had accumulated 'real world' experience and were able to reflect on their experiences and compare them to their initial perceptions of the nursing profession. During this phase, the students experienced a cognitive dissonance between their expectations and the reality that they were facing. The historical nursing identity and the contemporary nursing identity are both recognised as important by the second and third-year students. Being faced with a dual identity meant that students need to rethink their identity and develop ways to manage these identities in practice. The historical nursing identity was believed to be an important component of the way that the those outside of the profession viewed nursing and expected it to be. Second and third-year students described the reconciliation of the two identities. They understood that both traditional and contemporary nursing identities need to co-exist, with the nurse being able to move freely between them as the circumstances dictated.

The historical identity is used for presenting an image to the patients and public that nursing has not lost its connection to its roots. A contemporary identity is used to demonstrate professionalism and competence to educators, professional regulators, mentors and other healthcare professionals.

A third phase of identity re-alignment was identified in the narratives of the students in this study. This *Re-orientation* of identity was evident in the responses to questions about their future plans. As they looked forward to their professional life beyond nurse education, students aligned themselves to fields of nursing that they believed would be best suited to their own skills, qualities, goals and motivations.

It has been contended that the nursing profession is attempting to reconcile a duality of contemporary and historical identities within academic and clinical domains (Andrew et al. 2009, Andrew and Robb 2011). As students look forward and establish career goals, they identify potential academic and clinical pathways for their professional development. Many students in this study were clear about the place within the profession where they would be able to fulfil their own goals and use their individual strengths. The students interviewed in their final year recognised the range of possibilities available to them on qualification. Their view of contemporary nursing encompassed management, research, education and clinical specialism, in addition to more traditional ward-based nursing roles. This awareness of nursing's expanding professional roles was only realised towards the latter stages of the undergraduate programme. McKendry et al. (2012) suggest that students are vocationally orientated as a result of pedagogical emphasis on clinical demands, at the expense of developing academic skills; a conclusion that is highlighted in the

current study as being the origin of conflict in the development of Professional Role Identity. As the relevance of the historical nursing identity (that they had been so strongly aligned to in the first year) diminished. Students felt that the historical nursing identity was an anachronism, and no longer definitive of nursing practice. However, they also perceived a need to maintain certain aspects of traditional imagery for the benefit of reassuring their patients, and the public. This study suggests that the professional identity of nursing is constructed. Not by students themselves, but by a complex network of macrosocial influences that reproduce historical and contemporary discourses of nurses, and the nursing profession. A conclusion that can be drawn from this is that the student's Individual Professional Identity remains stable throughout the programme, whereas the alignment to a Professional Role Identity requires the reconciliation of conflict between the Historical and the Contemporary discourses that influence professional and pedagogical practices.

9.1.2.2 The Caring profession

The popular perception of nursing as the ‘caring profession’ can be interpreted in two ways: as a profession that is comprised of caring professionals; or that the aims and objectives of the profession are to care for others. Prefacing the noun ‘profession’ with the adjective ‘caring’ implies that it can be distinguished from other professions that might either lack (or not be primarily concerned with) caring. Nursing has a long association with the concept of caring. Wilkinson (1998) argues that caring is ‘an emotion-like state fitting with a general explanation of unified experiences of beliefs, desires and feelings’ (p2). From this perspective, caring is a descriptor of nurses’ attitudes to others; it describes the caregiver, rather than the care given. However, other definitions of caring allude to it as a verb; describing the activities of nurses (Morse 1990, Paley 2001, Radsma 1994). Whilst the distinction might seem to be a purely semantic point, the ambiguity of the terminology around nursing might account for the enduring label of nursing as the caring profession. If nurses ‘give care’ then, by definition that care must be ‘caring’; otherwise, absence of a caring attitude results in the oxymoron of ‘uncaring care’. This problematic language might also compound the public’s concern when ‘poor care standards’ are cited by the Care Quality Commission (CQC) or public enquiries such as the Francis report (DOH 2013). Thus, failing to provide nursing care through lack of time or low staffing levels, can easily be confused with a ‘lack of caring’ in the attitudes of nursing staff, when care and caring are used synonymously. The students in this study readily adopted the notion of nursing being a profession, but with special importance being placed upon its *duty of care* to the people the profession serves. Being caring and being professional were not described as mutually exclusive however. When these students described the professionalism that their role-models

possessed, they described an ability to function competently within professional boundaries whilst still retaining a strong sense of caring and compassion for their patients. Professionalism, to these students, is more than just acting in a professional manner, it is also the demonstration of personal qualities that portray a genuine concern for others. This study shows that students view the demonstration of care and compassion is not a case of 'going above and beyond' the minimum expected standard but is instead a normative expectation among professional nurses.

The concept of caring (upon which the nursing profession is built) is revealed as vague and ambiguous by the students in this study. This is consistent with existing literature on caring in nursing. Prior to the commencement of this study, a critical review of concept analyses was undertaken (Sargent 2012). The results of this literature review concluded that the attempts to accurately define caring had failed to provide a consistent or well-defined concept. Caring has been described as the ontological and epistemological foundation of nursing (Watson 1979, Cheung 1998) and as the essence and central focus for nursing (Leininger 1978). The advent of an epistemology for nursing in the mid-20th century that is based upon the premise of a caring science, has thus far failed to provide the nursing profession with a coherent concept of caring. In other reviews of the literature on caring, the concept was discovered to be defined simultaneously as: 1) a moral imperative; 2) an affect; 3) an interpersonal process; and 4) a therapeutic intervention (Morse 1990, Morse. J 1991). Much of the ambiguity around the concept might be explained its usage as a verb, adverb or adjective and, as such, will always be dependent on the context in which it is being used. To be 'caring for a patient' is commonly used by nurses to describe the act of providing nursing intervention. To act in a 'caring manner' towards a

patient implies an attitudinal approach rather than an intervention. Caring *for* and caring *about* might not be both present at any given moment, and yet the use of caring to define the nursing profession is pervasive and ubiquitous. It is therefore unsurprising that the students' narratives about caring continued this tradition of subsuming a range of qualities, behaviours and practices within this singular term. Analysis of the students' discussions did not advance the clarification of the concept with any more certainty than before. However, what can be revealed from this study is the way in which caring is discursively reproduced by the public and the profession. This caring discourse is evident in undergraduate curricula and in professional regulation, and hence has an effect on shaping professional identity. Students definitions of professional nurses invariably used the terms care or caring. This study shows that, as students progress through the undergraduate programme, they begin to define professional nursing in more precise terms. As student nurses gain experience of clinical practice, they are able to articulate the minutiae of the interpersonal relationships between nurses and their patients. In the early stages of the programme, this relationship is described in terms of the nurse's individual disposition (i.e as a caring person). At the latter stages of the programme, students learned that caring is a term that encompasses a range of skills such as therapeutic communication and ethical decision-making.

The term 'caring profession' serves to describe the humanitarian aims of nurses and the nursing profession. Furthermore, the assumption that nurses are inherently caring, and that being caring is a pre-requisite of entering a nurse education programme, is supported by the students in this study. However, if caring is a pre-requisite behaviour, then the inclusion of caring and compassionate practice to be

included in the undergraduate curriculum could be called into question. Furthermore, the use of language of about caring should be carefully scrutinised. Defining nursing practice as 'caring' lacks specificity about the nurse's professional role and alludes to that practice as being primarily concerned with personal qualities, rather than the essential skills required.

9.2 The Social Construction of Professional Identity

In this section, the processes of identity formation will be reframed into a broader social context through the social constructionist perspective. The role of societal discourse in the shaping of nursing (and nurse's) professional identity will be laid out; offering an alternative perspective on the prevalent theory of the socialisation of student nurses during the undergraduate programme.

Discourses systematically portray social events as language 'above the level of the sentence' (Blommaert 2005 p2). Around the subject of nursing there are many discourses that have been studied, for example: professional discourses (McNamara 2010), nurse-patient relationships (Crowe 2000); caring discourses (Canam 2008, Sargent 2012); discourses of managerialism (Gilbert and Gilbert 2005) and discourses of surveillance (Wilson 2001). Each discourse is a linguistic representation of an object; a means of presenting us with a way of interpreting social phenomena. Therefore, discourses are not definitions or sets of fixed meaning, but instead open up the possibility of understanding competing ideologies about socially constructed versions of reality (Belsey 2006). The role of discourse in the construction of identity questions the agentic nature of the self. Theorising identity as subjective, intersubjective or from a postmodern viewpoint, divides the literature. As laid out in section 2.2, the agency that an individual has in the adoption of an identity compartmentalises the theoretical positions that one might take when seeking to understand how identity comes into being. Some of the presented literature suggest a high degree of agency by the students (Traynor and Buus 2016, Thomas et al. 2015, Mazhindu et al. 2016, Shakespeare and Webb 2008), whereas

others do not (Kelly et al. 2017, Baldwin et al. 2017, Christiansen 2011). The consistency of the self is, likewise, the subject of some variation. Earlier assumptions about identity as *the project of the self*, have given way to more contingent and fluid interpretations (Benwell and Stokoe 2006). Whether student nurses actively adopt a professional identity, or whether there are other influencing forces that shape those individuals provides the point of departure for the following discussion. This study argues that professional identity is constructed socially and that student nurses embarking on the undergraduate pre-registration programme have been (and continue to be) shaped by social influences that are experienced both outside of and inside of the profession. Therefore, the development of a professional nursing identity is not a *project of the self* but is instead the project of societal forces. The dominant discourses of nursing provide a meta narrative within which students find themselves immersed. By interpreting the macro, meso and microsocial processes within students' discussions, as discursive practices, it becomes clear that there are commonalities and consistencies regarding the influence of these discourses. Students created meaning from their experiences of being a neophyte nurse and described the way that historical and contemporary discourse infiltrate the talk of friends and family, educators, nurses in practice, professional bodies, politicians, patients, and the public media. They described similar stories about how nursing is viewed by these various parties, which highlighted the discursive practices that construct the professional identity of nurses and the nursing profession. These discourses were described by the students as being reproduced from different sources and yet converge at various stages of the undergraduate student nurse's journey through the programme. Broadly defined here as Historical and Contemporary

discourse, the nursing profession's identity is shown to be constructed by these discourses in the narratives of the students.

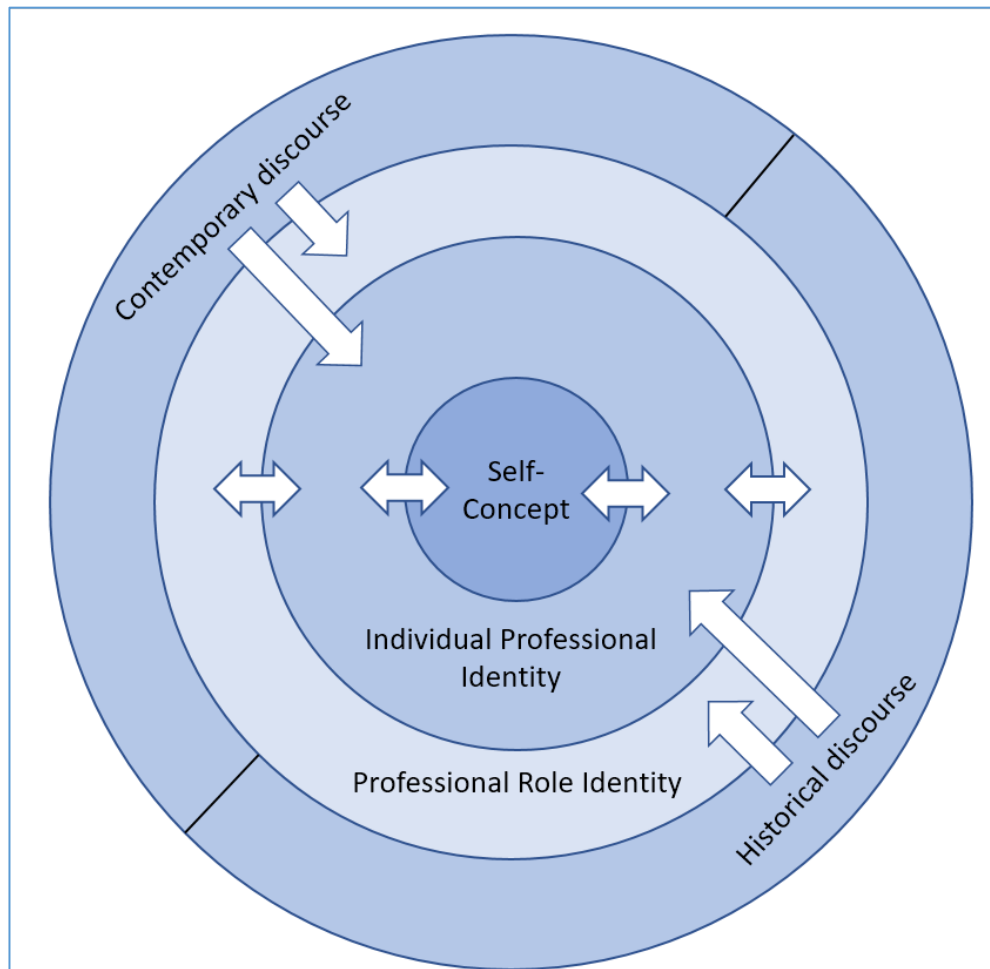


Figure 9-4 Discursive influence on PRI and IPI

In Figure 9-4, the relationship between the Historical and Contemporary discourses of nursing on the development of IPI and PRI is shown. The arrows in this diagram are unidirectional unlike those in the previous diagrams (Figure 9-1 and Figure 9-2). This demonstrates that the direction of influence goes from the social towards the level of individual and professional identities. In the following sections, the impact that these two dominant discourses of nursing identity have on the undergraduate student will be discussed.

9.2.1 Historical discourse

For the students of this study, nursing's past was defined broadly as any state of nursing that preceded the current situation. This history included nurse education that occurred prior to the recent changes, it also encompassed early incarnations of nursing from the time of Florence Nightingale. In Kelly et al. (2017), students were exposed to the history of nursing from a museum and asked to critically reflect on the impact that history has on contemporary practice. It was concluded that connecting the past with the present gave students a profound sense of commitment to the profession and reinforced their sense of professional identity. The students in that study held a perception that patients' expectations were built upon a historical view of nursing. However, they found these expectations to be conflicting with a more contemporary view of the profession. Kelly et al's study shows that the students are being offered two different versions of nursing; one based upon history and tradition, another that arises from the expectations of modern healthcare organisations. The commitment to the profession's identity that Kelly et al reported, does then raise a question regarding whether there is a benefit to the students by presenting them with a view of the past. Their awareness of the conflict between the historical and the contemporary identities of the nursing profession, implies that those students, by being asked to critically reflect on the past, were not necessarily choosing one identity over another, but were being asked to reconcile two disparate ideals. The students in the current study were clear that nursing's past might no longer be relevant to contemporary practice; an idea that was proposed 15 years earlier by Maggs (1996) and more recently by Mantzoukas (2002). However, it has also been suggested that nursing's history might still be relevant in nurse education if

those who teach it are themselves able to properly explain and contextualise it (Padilha and Nelson 2009). The students in this study referred to nursing's history as either a benchmark with which to highlight how much the modern profession has progressed, or in some cases, as an explanation for the current failings in care standards.

Contemporary nursing practice is shaped by and built upon the practices and social imperatives of the past; as with all institutions, the nursing profession has not spontaneously emerged but is indebted to its past. Institutions are created whenever (or wherever) there are reciprocal and habitualised actions that are performed by certain types of social actors (Berger and Luckmann 1967). Therefore, contemporary practice is a culmination of such habitualised practices that have been developed and refined throughout the history of the profession. However, the students drew a distinction between past practice and contemporary practice; the former being considered to be lacking in quality compared to the latter. The exigency of learning practices that they felt to be most relevant to their clinical placements, seemed to force a rejection of the practices of nurses who were not educated under the current nurse education system. Their identity of being the 'new generation' of nurses reinforced a perception that their goal was to correct, what they saw as, outdated practice.

The way in which nursing history is presented is worthy of some consideration. If a selective account of only positive aspects of past nursing is portrayed (through 'rose tinted glasses') then it is likely that students are being asked to commit to an

erroneous sense of being part of a tradition. Connecting with the past, or viewing the past positively creates a sense of nostalgia. Nostalgia can therefore be integral to the construction of identity (Gillett 2014) and as a mechanism for reinforcing group identity through the perspective of a shared past (Brown and Humphreys 2002). The positive effects of a group's history to the shared identity is essential for in-group behaviour (Tajfel and Turner 1986), however, this becomes problematic if the past identity is presented as being superior to that of the present. In a critical discourse analysis of British newspapers' reproduction of a nostalgic discourse of nurse education, Gillett (2014) suggested that nostalgic representations of nursing idealise the past and reinforce negative feelings about the present. The students in the current study were interviewed during a time where the recent transition to an all-graduate nursing profession was still being debated in the public and professional media. This schism between historical and contemporary constructions of nursing's professional identity reveals contrasting perspectives, with powerful voices on each side reproducing conflicting discourses about the nature of nursing, and the educational attainments of nurses. Despite its advocates in the professional and public domain, this study highlights how students view nursing of the past as being associated with a low educational status, a passive and powerless workforce, lower standards of care, and the focus on caring behaviours. Whilst they held a perception that nursing is proud of its history, the students did not associate this with their own developing sense of professional identity. Particularly once they had encountered 'real world' experience during the undergraduate programme.

9.2.2 Contemporary discourse

The modern nursing profession is defined by students in terms of its mandatory graduate entry, its established post-graduate pathways, its emphasis on critical decision-making, its role in policy-making and knowledge development, its leadership role in multi-disciplinary teamworking, and its emphasis on clinical change management. Role-models who demonstrated skill in these elements of nursing practice reinforce the contemporary discourse of nursing identity to students. Exemplars of good nursing, however are observed in nurses who are able to reconcile elements of both historical and contemporary nursing identities. This indicates a fluidity to professional identity that has, until now, not been fully explored. Professional identity of nursing is generally conceived as being a fixed and objective descriptor of professional practice; it is a framework for professional development that is a frame of reference for professional socialisation (Du Toit 1995, Feng 2012). Socialisation and professional identity formation are often presented as being synonymous or simultaneous processes (Adams et al. 2006b, Castledine 2003a, Grealish and Trevitt 2005, Thomas et al. 2015, Zarshenas et al. 2014). Socialisation is the 'process by which professionals learn during their education and training, the values, behaviours and attitudes necessary to assume their professional role' (Howkins and Ewens 1998: p41). Alternatively, Berger and Luckmann (1967) define secondary socialisation as the process by which a person undergoes the internalisation of the social world as a subjective experience. Experience, in this case, is socially derived and integrated with the individuals own subjective sense of self. The similarity is clear between the two definitions provided here; learning and internalisation of experience both result in altered behavioural

characteristics in the individual. It is the subjective internalisation of the social world that is of interest in this study. The primary argument of this thesis is that students are attempting to internalise the social world but are often finding conflicts between the social worlds being presented to them. For example, the public discourse of nursing that is aligned to a nostalgic historical view of nursing is, at first, irreconcilable with the contemporary view of nursing as portrayed by the profession in recruitment materials, and as often experienced in practice. As discussed in section 9.1.2.1, students re-align their identity and learn to manage the conflicts between these conflicting identities as they progress through the programme.

Role-models are selected by the students on the basis that they represent their own ideas about what nurses should be like. The frame of reference for choosing one nurse over another as a potential role model is of interest here as the decision must be based upon the individual students internalised perception of what constitutes an ideal role-model. Role-modelling is a negotiated process between nurse and student; it is a process that is fluid and dynamic rather than fixed (Baldwin et al. 2017). If the relationship between student and role-model is intersubjective (as this would suggest), then there is still the outstanding question about the terms of reference of this relationship. It should be assumed that both parties are basing their Individual Professional Identities upon the same discursive foundations; they are aligning their shared perceptions of what they perceive to be a professional nurse, even though they have both been educated under different systems. Therefore, the dominant discourse of nursing's professional identity has its origins at a level above that of the education institution; the HEI simply reproducing this discourse, rather than creating it.

9.2.3 Reproduction of discourse

The discourses (such as those discussed in the previous sections) provide a systematic and coherent set of meanings, images, metaphors and statements that produce a particular version of events (Burr 2015), in this case, the professional identity of nursing. Just as language is used to produce a version of events, the events themselves produce knowledge through the language used. For example, as described earlier, the language around the concept of caring has been developed into a systematic body of knowledge that we might know as *caring science*. In turn, nursing's epistemology has subsequently been built upon the foundations of caring as a central and defining concept. As a result, the language of caring has become the basis of the nursing lexicon. Michel Foucault defined discourse as 'practices that systematically form the objects of which they speak' (Foucault 1972: p49). This somewhat circular reference indicates this reciprocal relationship between language, and the meaning that is derived from it. Foucauldian interpretations of power and the reproduction of discourse of discourse have been used widely in nursing research (cf. Fejes and Fejes 2008, Hayter and Hayter 2007, Huntington and Gilmour 2001, Irving et al. 2006, Stevenson and Cutcliffe). In this study, elements of Foucauldian thought are in evidence. The reproduction of a caring discourse through the publication of the Chief Nursing Officer of Great Britain's '6C's' (Cummings 2012), was interpreted by students as an example of how the profession (on behalf of the UK government) was able to re-establish trust in the public. Despite the overwhelming perception by students that this publication was an unnecessary distraction from the actual problem in the profession (inadequate funding and low staffing numbers), students

understood the power that such rhetoric can have on the public and the way that it shapes nursing's identity.

The students recognised that the profession's identity as passive and powerless in the face of negative criticism about care standards was in evidence whenever a response was given by the nursing profession. A statement by Peter Carter (the General Secretary of the Royal College of Nursing at the time), was reported in *The Times* newspaper, claiming that student nurses 'lacked the skills to care for their patients' (Smyth 2011). When shown to the students during the focus groups of this study, the reaction was that of anger and frustration. Anger, that their personal qualities to be a nurse had been questioned, and frustration that a professional body that was supposed to defend them was, in fact agreeing with the public and political criticism of the new nurse education system. The reproduction of a discourse that questioned contemporary nurse education, by emphasising the virtues of historical approaches to nurse training, generated the most significant reaction from the students. The reproduction of historical discourse that supports a nostalgic view of the profession's identity is therefore both unhelpful and inhibitory in the development of students' contemporary nursing identity.

Nurse educators are important agents of discourse for students during their pre-registration education. New entrants to the programme are dependent on the university to provide a coherent framework for professional practice, from which their professional role identity will be constructed. Principally, the NMC Code is used as a basis for defining the role of the nurse and outlining expectations. Towards

the later stages of the programme, once students accumulate significant experience, the students become critical of the identity of the nurse, as presented to them by nurse educators. Furthermore, the continuous reference to negative cases (e.g. poor practice and unprofessional behaviour) in learning situations reproduce a public perception that such examples are widespread. It appears that, like the examples given above, that the response to public criticism of the profession is to over-compensate for a perceived lack of caring; in doing so, reproducing and reaffirming that criticism to the students, rather than challenging it.

10 Conclusion

Nurse education is responsible for the development of skills and knowledge required for professional practice. However, this thesis argues that the role of nurse education in the development of student nurse's professional identity has potentially been overstated and misunderstood. Students enter their pre-registration undergraduate education with a pre-determined image of professional nurses, and of the role that professional nursing fulfils in society. Student's images of professional nurses are already well defined in terms of the personal qualities and characteristics required of a 'caring professional'. The image of the nursing profession is frequently defined in terms that describe it as passive and powerless to defend its role in contemporary healthcare. The language of caring creates some ambiguity about the nursing profession. Caring is defined as an attribute that nurses possess, but it is also used to describe nursing practice. This ambiguity increases the likelihood that nursing practice is perceived as being founded purely upon affective behaviours, and that the extensive range of skills required for modern nursing are rendered invisible. Explicit articulation of the full range of skills, knowledge and personal qualities of the professional nurse is required if the nursing profession is to be presented accurately.

Public discourses of nursing construct the Individual Professional Identity (IPI) and the Professional Role Identity (PRI) of student nurses. The former remaining stable throughout the period of nurse education, the latter becoming transformed when found to be conflicting with more contemporary perspectives on professional nursing. By the end of the undergraduate pre-registration programme, students learn to manage their individual and their professional role identities. Individual

Professional Identity (IPI) is an extension of the student's self-concept. The relationship between the student's self-concept and their IPI is mediated through a process of managing authenticity. Autonomy is revealed to be a mediating process between the nurse's IPI on nursing's Professional Role Identity (PRI). Professional identity is therefore constructed through sub-processes of Managed Authenticity and Managed Autonomy.

This thesis has shown how the professional role identity of nursing is constructed socially; it is a product of disparate and competing discourse. The reproduction of public discourse that both celebrates nursing and criticises it, infiltrates the students' development of professional identity. Students' professional identity is constructed via representations of the nursing profession that students internalise from the profession, and from the university. However, these representations are evidence of how reproductions of macrosocial discourse influence the students before and during their undergraduate education. The clinical practice placement offers students the opportunity to be exposed to these discourses through the observation of role-models. These role-models are individually selected exemplars of good practice that are chosen on the basis of their similarity to the student's own attributes. It is in the role-models' management of their authenticity and autonomy- in the context of the competing discursive formations- that students construct professional identity. Discourse therefore performs ideological work and disseminates ideas to students as 'taken for granted' assumptions about the identity of nurses and nursing.

10.1 Contribution to knowledge

This thesis argues that professional identity development among undergraduate pre-registration student nurses, can be extended to include two factors: 1) That professional identity is not a single entity, but is comprised of two distinct concepts; 2) That professional identity is not an outcome of the education process, but is a social construction that is internalised by students prior to their entry onto the undergraduate programme.

Undergraduate pre-registration students understand professional identity in two distinct ways; professional identity of *nurses* and professional identity of *nursing*. This study suggests that the assumption of a single unified identity fails to account for the conflict between the student nurse's perception of what it means to be a nurse and how the role of the nursing profession is identified. As such, this study claims that professional identity in nursing should be sub-divided into two distinct concepts: Individual Professional Identity (IPI) and Professional Role Identity (PRI). Where IPI might previously have been thought of as synonymous with self-identity, this study contends that IPI is an extension of (but discreet from) self-identity. The influences that construct the IPI and PRI appear to have the same macrosocial origins. However, these constructions are rationalised and internalised in different ways. Individual professional identity is internalised through reflection on the authentic self, whereas professional role identity is viewed as that which is imposed through a public and professional discourse of nursing. This thesis suggests that nursing's history has a powerful, inhibitory and repressive influence on nursing's

PRI. Conversely, the evolution of undergraduate nurse education, and the widening scope of the nurse's clinical role is seen to have a positive influence on IPI.

The development of professional identity is not simply a product of the socialisation of student nurses into the realm of professional practice, as it has been previously claimed and assumed. Instead, student nurses enter the undergraduate pre-registration nursing programme with an established sense of who nurses are (IPI) and how nursing is presented and perceived (PRI). Whilst some refinement of their understanding does take place through the acquisition of concrete experience, perceptions remain stable throughout the three-year programme. This thesis reframes the socialisation process of student nurses, by suggesting that it is the acquisition of strategies that enable them to sustain their existing concept of professional identity. For example, balancing the use of formality and professional distance with the development of meaningful and informal interpersonal relationships with patients. Such strategies are developed as a response to the conflict that they perceive between their individual professional identity and the professional role identity during their undergraduate experiences.

By examining professional identity through the lens of social constructionism, this thesis offers new insights that are both illuminating and emancipatory. Revealing professional identity as that which is internalised through habitualised social practices, rather than that which is actively learned, offers new understandings about the role of nurse education in identity formation. Emancipation can arise from reflection on this alternative understanding. The awareness of how students develop

professional identity informs pre-registration pedagogy through the creation of undergraduate curricula that is forward-looking and not bound to outdated and incompatible images of the profession.

10.2 Implications for nurse education and practice

In the field of undergraduate pre-registration nurse education, this thesis offers an opportunity for a pedagogical re-examination of some taken-for-granted assumptions about student nurses. Where existing literature assumes that professional identity is developed as a result of the education process, this thesis argues that one component of professional identity (IPI) pre-exists and remains stable throughout the socialisation process. As a result, the requirement for teaching certain elements of IPI (notably the attributes of being caring and compassionate) is questioned. Furthermore, teaching student nurses about the history of nursing (or making reference to outdated practices) might reinforce out-dated images of professional nurses and inhibit the student's development of contemporary professional role identity. The history of nursing should serve only as a context for existing practice, and not as a framework for future professional development. This can be achieved by orientating students towards the challenges that face nursing in its contemporary and future professional role identity, thereby reducing the conflict between historical and contemporary discourses of nursing. Professional nurses and educators should be alert to the possibility of reinforcing negative images about nurses and should attempt to negate anachronistic images of the nursing profession as being passive and powerless to affect change. Therefore, students should be encouraged to critically evaluate their pre-existing ideas about nursing and should be facilitated towards an understanding of the role that the nursing profession has in articulating its contribution to the future of healthcare.

The recruitment of nurses onto the undergraduate pre-registration programme should continue to scrutinise the applicants' personal qualities as potential nurses. The ability for these future professionals to be able to withstand the challenges of professional practice should naturally also be established. However, applicants whose understanding of nursing's professional identity- that has been built upon outdated images of the nursing profession- might experience higher levels of conflict when faced with contemporary practice. Emphasis on being caring and compassionate, at the expense of leading and changing practice, might slow the progression of the nursing profession as it responds to the rapidly changing, and increasingly diverse challenges within the nurse's professional role.

10.3 Recommendations for future research

This thesis has provided an alternative view of nursing's professional identity in which it is constructed through public discourse. Nursing is framed as the subject of such discourse but is also complicit in reproducing an image of nursing that no longer fits with its professional role and objectives. A number of avenues for further research have opened up as a consequence of this study. These studies should further explore the ideas presented and reinforce the integrity and robustness of the findings in this thesis.

Further elaboration on how nurse education reproduces discourse in the undergraduate curriculum, is required. This study examined the views of students only. It is suggested that further in-depth qualitative research is undertaken with educators, through interview, observation of teaching and through examination of curricula, to explore pedagogical practices that influence students' perception of professional identity.

The origin of student nurses' perceptions of Individual Professional Identity (IPI)- and factors that maintain its stability throughout the undergraduate programme- have been presented in this thesis. However, further research is needed to test this hypothesis on a larger population of student nurses (including those who might not have self-selected themselves for the current study). Therefore, a longitudinal quantitative survey evaluating students' perceptions of IPI throughout the

programme, would strengthen the thesis' claim that undergraduate education requires less emphasis on the students' IPI development.

Further research is suggested to develop ideas emerging from the findings of this study. These studies should explore:

- The extent to which role-models chosen by students actually share similarities in IPI, or whether this is purely a perception of the student.
- The perception of nursing's professional identity by those who decide against a career in nursing. To gain an understanding of the impact that negative public discourse has on nurse recruitment.
- The way that student nurses manage the authenticity between self-concept and IPI in practice situations where conflict arises.
- The impact of gender on the interpretations of professional identity, and the role that it has upon the development of identity in the nursing profession.
- The way in which nurses manage their autonomy during practice situations where IPI and PRI conflict.
- A critical discourse analysis of how traditional perceptions of the nursing profession are revealed in professional texts. This analysis could explore how

professional regulatory statements (NMC code) and professional rhetoric from professional leaders, construct nursing's professional role identity.

- With the growing use of social media among professional nurses, there is a potential to explore how discourses of nursing are produced and reproduced intra-professionally. Thus, revealing the confluence of public and professional discourse, and its influence on professional nurses' identity.

10.4 Strengths and limitations of the study

The strengths of this study include the methodology, the insider perspective, sampling of study sites, the diversity of the student sample, the longitudinal design of the research and the attention to rigour. Previous studies have adopted the position that the researcher's influence on the data might introduce bias and a lack of objectivity in the analysis. However, the choice of the constructivist grounded theory method provides an appropriate framework with which to examine the nursing profession as a social construction. This is due to constructivism's emphasis on intersubjectivity. As identity is a social phenomenon, its exploration from an objective standpoint is hard to reconcile when the researcher exists in the same social world as the participants. Furthermore, the insider perspectives provided by the researcher has benefitted the interpretation of student's accounts by increasing theoretical sensitivity in the data analysis and has facilitated the students' reflections on practice. The use of students from two universities allowed for a broad range of perspectives to be gathered during the focus groups. Furthermore, the sample size of 63 participants ensured that a large volume of data could be collected. The composition of the sample was diverse and included the broadest possible range of students. Participants included representations from: all programme branches; both male and female students; students with varying amounts of prior care experience. This diversity in the sample was a key strength to the open exploration of the topic during the focus group phase.

Attention to rigour in this study is a further strength of the thesis. The comparison of focus group data within (and between) each research site ensured that emerging

themes could be compared, contrasted and verified. Furthermore, the longitudinal element, whereby focus group data guided follow-up interviews a year later, revealed transitional elements of identity formation. The rigor of the study was enhanced by the recording of field notes during data collection, memo writing during analysis, reflective engagement with the data (with colleagues and research supervisors), and by including a reflexive statement in the thesis.

A limitation of this study was that both research sites were located in the same city. The inclusion of students at a university in another city, or in a more rural setting, might have revealed different insights and experiences. The longitudinal data collection did not follow individual students for the entire duration of the programme; only for one year. Whilst this method did reveal transformations and stabilities in the students' professional identities, comparisons of data from year 1 to year 3 might have offered further understandings.

The study only included the students' subjective experiences and did not seek the perspective of others involved in their professional development (such as educators and mentors in practice). Therefore, the conclusions are based upon professional identity only as the students perceive it. This limitation is partially mitigated through the constructivist grounded theory method, in which the researcher (an educator) is co-constructor and interpreter of these perceptions.

The students in this study offered their participation voluntarily. Whilst this good research practice, it presents a limitation since the students were self-selecting.

Without exception, the participants were all enthusiastic, committed and keen to articulate their views about nursing. These self-selected participants were encouraged to be honest and to offer negative as well as positive opinions where possible, but there is a possibility that students who were disaffected, burnt-out, lacked the time, or wished to become a nurse for reasons other than those set out in the discussion chapter of this thesis, may not be represented in the study's conclusions. However, after analysing the data, there was confidence that the students did give some responses that were deemed to be socially undesirable, and that many criticisms of nurses, the university and the profession, were expressed. There is no way of knowing if the responses given by these students truly reflect those of the entire student population, but generalisation of these findings is not required or appropriate to the endeavour of qualitative grounded theory research, which seeks to generate and apply theoretical insights, rather than to reveal an objective world.

Attempts were made to mitigate the potential influence of power in the relationship between researcher and student, given my role as an educator. However, the existence of that influence on the responses of students cannot be accounted for with any certainty. A further potential limitation is that this study is limited to a specific period of time in the careers of the student nurses; with data only collected during their pre-registration education. The scope of the study did not allow for an exploration of how nursing's professional identity is perceived by those yet to enter the programme, or after qualification. The discussions in focus groups and interviews often referred to experiences and perceptions of nursing held by students

prior to enrolment on the programme. The issue of selective memory in these responses could not be addressed in the design of the study.

The issue of gender in interpretations professional identity was not fully explored. The influence of the nursing being a primarily female profession has not been entirely overlooked in this study, but it has not been a central focus either. It is recognised that the exploration of gender in professional spheres opens up a wide range of alternative explanations about the nurse's image. This avenue of inquiry has been left open for future investigation.

10.5 Reflection on the process

As with all journeys of any importance, the story begins before the first steps are taken. The decision to undertake such a huge endeavour like a PhD requires sufficient commitment and curiosity to sustain the energy required for the long road ahead. The choice of topic for the study, like so many others, arose from the cognitive dissonance experienced in my first days as a university lecturer. Having moved out of the realm of clinical practice and into the classroom, I was confident that I knew enough about nursing to make the transition from clinician to educator. I also believed that my own experiences as a student nurse (some 15 years before) held me in good stead to prepare the future generations of professional nurses. What surprised me was that, far from all being like myself as a student, each new student that I met seemed to have a very different idea about what professional life held for them in the future. The education that was being offered to them did not always meet their expectations; they were adult learners and had very clear ideas about what they needed to learn in order to achieve their goals. In the classroom, it was evident that each student had their own identity as a person, with often very different personalities and outlooks on life. However, these same students seemed to readily conform to a uniform typology when in clinical placements or in more formal situations. I was left wondering “who are these students?” and “what makes them the way they are?”. My critical concern became about how an individual becomes a member of a professional group and, in the case of nursing, why members of this group adopt such uniformity in their professional identity. Evaluating the literature on socialisation and professional identity in nursing uncovered a wide range of ideas

about the subject of *how* students become professional nurses. And yet, none seemed to satisfy the overriding question in my mind, that is *why* they become the nurses that they do? I needed to understand what processes are at work that shape the profession's identity and, by extension, how we educators can build curricula that bring neophyte nurses nearer to their goals in a way that preserves their unique abilities and attributes, rather than making them conform to pre-ordained types. After extensive reading, it became clear to me that I needed to step back and review what is already known about professional identity by casting the net wider than individual students. I wanted to look further, beyond the scope of the undergraduate programme, and into the social space that the nursing profession occupies. I wondered what power might be at work that shaped the general assumptions made about nurses and the nursing profession. I knew that this would be an ambitious endeavour. I proceeded regardless.

Writing the research proposal and the ethical approval forms for this study forced me to transform a vague area of concern into a clear question and a rigorously designed study. Undertaking additional modules on advanced research methods afforded me the opportunity to discuss my research ideas with other students. I was also given the opportunity to attend a summer school for PhD students that was hosted by the European Academy of Nursing Science (EANS). Here, I was able to present my research proposal, and have it systematically deconstructed by experts in unrelated methodologies. Refinement of the final research design was an iterative process that required me to ask fundamental questions about my aims and objectives. These questions were "what am I actually trying to find out?" and "why does anyone need to know this?".

Recruiting participants and arranging the focus groups and interviews, was one of the greatest challenges faced in this study. Finding participants who would be willing to give up some of their spare time for no reward, was asking a lot from an already overworked student population. I was pleasantly surprised by the enthusiasm with which the participants bought-in to the project. Some students even claimed to have enjoyed just having the opportunity to talk about themselves and the nursing profession. There was a certain reflective aspect to many of the interviews. This was intentional to a certain extent. My past experience of facilitating clinical supervision sessions was useful in helping students to articulate ideas that were hard to explain.

The process of undertaking a study of this magnitude and importance was intimidating, mentally challenging and, at times overwhelming. Managing high volumes of textual data, trying to make sense of what it was telling me, and staying focused on the original aim of the study has been the hardest part of the process. I have made use of those around me to discuss ideas as they emerged. Colleagues in my institution and friends that I have made who were sharing the PhD journey, listened patiently as I attempted to articulate my thoughts. Talking to students about my study also gave me a sense that I was doing something worthwhile. Several past students contacted me to ask about my progress and have voluntarily given feedback on my tentative conclusions. The positive responses that they gave have contributed to the sense that I have not only undertaken this study for my own development, but also that I am doing it on their behalf as well.

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TL;DR- Nursing's professional identity is socially constructed

Appendix 1 – Daily Mail headline “Too clever to care”

Daily Mail headline used to promote discussion about degree educated nurses in the focus groups.

MailOnline health

Too clever to care?

by CHARLOTTE GILL, Daily Mail
Last updated at 11:38 26 April 2004

The traditional caring role of nurses could soon be a thing of the past.

Nursing staff will vote next month on whether they should give up providing basic bedside comforts and concentrate instead on more technical tasks.

They will decide whether jobs such as bringing a patient a cup of tea, holding their hand or giving them a bed bath should be done by healthcare assistants.

A proposal to be considered at the Royal College of Nursing's annual congress will suggest nurses are now "too clever to care".

They are increasingly called on to improve their technical skills, carrying out work which was previously done by doctors such as performing minor surgery, medical procedures and prescribing drugs.

Patient care fears

Critics of the changes say the core role of their profession - caring for the patient - is being lost.

Appendix 2- Focus group discussion guide

Facilitator- Andrew Sargent

Moderator- Karen Gillett

Focus group size 6 persons.

Approximate time 30-40 minutes.

Session overview

1. Introductions
2. Test sound levels of recording equipment
3. Brief explanation of the study and the purpose of the interview:

Example-

Thank you for agreeing to take part in this research, I am very keen to hear your opinions on a number of issues relating to nursing.

Can I just remind you that your responses to the questions will be treated confidentially and that your name will not appear on any results that arise from this study. However, I must tell you that should you wish to reveal any information pertaining to an act or behaviour that is in breach of professional practice that I am duty bound to report it to the relevant authority.

4. Commence discussion

*The aim of this session is to encourage discussion around the topics rather than to get the students to answer questions directly

Topic 1- The role of the nurse

Focus- How do students perceive the role of the nurse?

Example cue questions:

1. How would you describe the role of the nurse to someone who is not a nurse him/herself?
2. What are the different roles that nurses have?
3. What do nurses offer that others don't?
4. How do you think that the role of the nurse today compares with the past?

Topic 2- The nursing profession

Focus- What does it mean to be a professional nurse?

Example cue questions:

1. How might you define professional nursing?
2. What is it that professional nurses do that other carers don't?

3. How does the nursing profession compare to other professions (healthcare or otherwise)?
4. What values and attributes do you associate with professional nurses?

Topic 3- The public image of nursing

Focus- how do nurses react to public perceptions of nurses?

Example cue questions: (show participants some recent newspaper cuttings about nurses in different lights)

1. There is a lot of talk about nursing in the media these days, what do you think about this?
2. What is a nurse's role in society?
3. What is good/bad about the image of nursing?
4. How do other healthcare professionals view nursing?

Appendix 3- Focus Group Information sheet



Postgraduate Research Study

Discursive practices and the construction of professional identity in the socialisation of pre-registration undergraduate student nurses

Protocol Number: **PNM/13/14-54**

INFORMATION SHEET FOR PARTICIPANTS- Focus groups

You are being invited to be involved in a post-graduate research study. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully. Please contact me if anything is unclear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

This study aims to try and understand how undergraduate nursing students develop their understanding of the professional role of the nurse as they progress through the pre-registration nursing programme. This study is being conducted by Andrew Sargent, a PhD student at King's College London.

Why have I been chosen?

You are being invited to take part in this study, as you currently enrolled on the undergraduate nursing programme at a London University and therefore you are in a good position to offer insight into the professional role of the nurse from the perspective of a student. Your views on the topic will help us as a profession to develop ways in which to facilitate the transition of students into professionals.

What will participation involve?

You are being invited to take part in a small group discussion (focus group) of about 6 students from your cohort, which will take place in the school. You will be asked to give your views and opinions on current issues in nursing and the current status of the nursing profession. Your experiences before and during this programme are a particular interest to this study.

The focus group will take approximately 40 minutes and will be quite informal in nature. It will take place at a time that does not conflict with any other timetabled activities. The discussion will be audio recorded, and later transcribed into text form. Recordings of interviews will be deleted upon transcription. You will be able to view a copy of the final report for verification purposes if you wish.

As part of the presentation of results, your own words will be used in text form. This will be anonymised, so that you cannot be identified from what you said. All of the research data will be stored as hard copy at Kings College London for no more than 3 years.

Please note that:

- Your participation in this study is not a part of your BSc(Hons) programme; your progress on the programme will not be benefited in any way by your participation. Nor will you be disadvantaged by deciding not to participate.
- You can withdraw your participation in the discussion at any time up until the beginning of the focus group (on the date arranged) without reason.
- You need not reveal information that you do not wish to.
- Your name will be removed from the information and anonymised. Your personal tutor, module leaders, programme leaders or Link lecturers will be **unaware** of your participation or the opinions that you express.
- It will not be possible to identify you from in final reports on this study.

It is up to you to decide whether to take part or not. If you decide to take part you are still free to withdraw any time up until the beginning of the focus group, without giving a reason.

If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form.

If this study has harmed you in any way you can contact King's College London using the details below for further advice and information:

Appendix 4- Consent form for focus group

CONSENT FORM FOR PARTICIPANTS IN RESEARCH STUDIES



Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.

Title of Study:

The formation of professional identity in pre-registration undergraduate student nurses

Focus groups

King's College Research Ethics Committee Ref: PNM/13/14-54

Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

- I consent to the processing of my personal information for the purposes explained to me. I understand that such information will be handled in accordance with the terms of the Data Protection Act 1998.
- The information that you provide will be published as a thesis and you may request a copy of the final report. Please note that confidentiality and anonymity will be maintained and it will not be possible to identify you from any publications.
- I understand that if I decide at any time during the research that I no longer wish to participate in this project, I can notify the researchers involved and withdraw from it immediately without giving any reason. I understand that due to the interdependent nature of focus groups it may not be possible to remove my ideas and views expressed in the discussion from the study.

- I consent to the audio-recording of my contribution to the focus group.
- I understand that discussions in the focus groups are confidential and this must be maintained by participants.

Participant's Statement:

I _____

agree that the research project named above has been explained to me to my satisfaction and I agree to take part in the study. I have read both the notes written above and the Information Sheet about the project, and understand what the research study involves.

Signed

Date

Investigator's Statement:

I, Andrew Sargent confirm that I have carefully explained the nature, demands and any foreseeable risks (where applicable) of the proposed research to the participant.

Signed

Date

Appendix 5- Interview Information Sheet

Postgraduate Research Study

The formation of professional identity in pre-registration undergraduate student nurses

Protocol Number: **PNM/13/14-54**

INFORMATION SHEET FOR PARTICIPANTS- individual interviews

You are being invited to be involved in a post-graduate research study. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully. Please contact me if anything is unclear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

This study aims to try and understand how undergraduate nursing students develop their understanding of the professional role of the nurse as they progress through the pre-registration nursing programme. This study is being conducted by Andrew Sargent, a PhD student at King's College London.

Why have I been chosen?

You are being invited to take part in this study, as you currently enrolled on the undergraduate nursing programme at a London University and therefore you are in a good position to offer insight into the professional role of the nurse from the perspective of a student. Your views on

the topic will help us as a profession to develop ways in which to facilitate the transition of students into professionals.

What will participation involve?

You are being invited to take part in an individual interview, which will take place in the school at a time that is convenient to you. You will be asked to give your views and opinions on current issues in nursing and the current status of the nursing profession. Your experiences before and during this programme are a particular interest to this study.

The interview will take approximately 20-30 minutes and will be quite informal in nature. It will take place at a time that does not conflict with any other timetabled activities. The discussion will be audio recorded, and later transcribed into text form. The recording of the interview will be deleted upon transcription. You will be able to view a copy of the final report for verification purposes if you wish.

As part of the presentation of results, your own words will be used in text form. This will be anonymised, so that you cannot be identified from what you said. All of the research data will be stored as hard copy at Kings College London for no more than 3 years.

Please note that:

- Your participation in this study is not a part of your BSc (Hons) programme; your progress on the programme will not be benefited in any way by your participation. Nor will you be disadvantaged by deciding not to participate.
- You can withdraw your participation in the discussion at any time up until the end of the interview, without reason.
- You need not reveal information that you do not wish to.

- Your name will be removed from the information and anonymised. Your personal tutor, module leaders, programme leaders or Link lecturers will be unaware of your participation or the opinions that you express.
- It will not be possible to identify you from the final reports of this study.

It is up to you to decide whether to take part or not. If you decide to take part you are still free to withdraw any time up until the beginning of the interview, without giving a reason.

If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form.

If this study has harmed you in any way you can contact King's College London using the details below for further advice and information:

Appendix 6- Consent form for interview

CONSENT FORM FOR PARTICIPANTS IN RESEARCH STUDIES

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.

Title of Study:

The formation of professional identity in pre-registration undergraduate

student nurses

Individual Interviews

King's College Research Ethics Committee Ref: PNM/13/14-54

Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

- I consent to the processing of my personal information for the purposes explained to me. I understand that such information will be handled in accordance with the terms of the Data Protection Act 1998.
- The information that you provide will be published as a thesis and you may request a copy of the final report. Please note that confidentiality and anonymity will be maintained and it will not be possible to identify you from any publications.
- I understand that if I decide at any time during the research that I no longer wish to participate in this project, I can notify the researchers involved and withdraw from it immediately without giving any reason. I understand that due to the interdependent nature of focus

groups it may not be possible to remove my ideas and views expressed in the discussion from the study.

- I consent to the audio-recording of the interview.
- I understand that discussions in the focus groups are confidential and this must be maintained by participants.

Participant's Statement:

I _____

agree that the research project named above has been explained to me to my satisfaction and I agree to take part in the study. I have read both the notes written above and the Information Sheet about the project, and understand what the research study involves.

Signed

Date

Investigator's Statement:

I, Andrew Sargent confirm that I have carefully explained the nature, demands and any foreseeable risks (where applicable) of the proposed research to the participant.

Signed

Date

Appendix 7 - Recruitment email / Letter

Title of Study: The construction of professional identity in pre-registration undergraduate nursing students.

Circular email for use for recruitment of volunteers for study ref: **King's College Research Ethics Committee Ref: PNM/11/12-124**. This study has been approved by The Psychiatry, Nursing & Midwifery Research Ethics Sub Committee, King's College London. This project contributes to the College's role in conducting research, and teaching research methods. You are under no obligation to reply to this email, however if you choose to, participation in this research is voluntary and you may withdraw at any time.'

I would like to invite you to take part in a study to explore the way in which student nurses develop their professional identity throughout the pre-registration undergraduate programme at King's College London. Of specific interest is the ways in which student nurses develop the ideals and values associated with the nursing profession.

I am looking for participants for this study who are currently enrolled on an undergraduate pre-registration nursing programme in the Florence Nightingale School of Nursing and Midwifery. You may be at any stage of the three-year programme to participate. All students who meet this description are eligible to participate unless they are personal students of Andrew Sargent who is leading this research (Tutor, Adult nursing department) or Karen Gillett (Lecturer, Specialist Care) who is co-facilitating the focus groups.

If you agree to take part in this study, you will be offered the opportunity to take part in a focus group discussion made up of no more than 8 students will take place in [redacted] building at a convenient time. This focus group will last around 45 minutes and will involve participants to discuss some current issues relating to nursing and the nursing profession.

If you are interested in learning more about this study and are eligible to participate, you will be sent an information sheet and a questionnaire. We may then contact you to invite you to take part in the study. Even if you are invited to participate, you are still free to decline.

Please contact Andrew Sargent ([redacted]) if you have any questions or are interested in participating.

Appendix 8 – Focus group discussion guide

Session overview

Introductions

Test sound levels of recording equipment

Brief explanation of the study and the purpose of the interview:

Example-

Thank you for agreeing to take part in this research, I am very keen to hear your opinions on a number of issues relating to nursing.

Can I just remind you that your responses to the questions will be treated confidentially and that your name will not appear on any results that arise from this study. However, I must tell you that should you wish to reveal any information pertaining to an act or behaviour that is in breach of professional practice that I am duty bound to report it to the relevant authority.

Commence discussion

*The aim of this session is to encourage discussion around the topics rather than to get the students to answer questions directly

Topic 1- The role of the nurse

Focus- How do students perceive the role of the nurse?

Example cue questions:

5. How would you describe the role of the nurse to someone who is not a nurse him/herself?
6. What do nurses offer that others don't?
7. How do you think that the role of the nurse today compares with the past?

Topic 2- The nursing profession

Focus- What does it mean to be a professional nurse?

Example cue questions:

5. How might you define professional nursing?
6. What is it that professional nurses do that other carers don't?
7. How does the nursing profession compare to other professions (healthcare or otherwise)?
8. What values and attributes do you associate with professional nurses?

Topic 3- The public image of nursing

Focus- how do nurses react to public perceptions of nurses?

Example cue questions: (show participants some recent newspaper cuttings about nurses in different lights)

5. There is a lot of talk about nursing in the media these days, what do you think about this?
6. What is a nurse's role in society?
7. What is good/bad about the image of nursing?
8. How do other healthcare professionals view nursing?

